95 20001

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Everett H. Ark			2. DATE OF DEATH (Month, Day, Year): June 9, 1995	3. TIME OF DEATH: 3:10 P.M M
4. SOCIAL SECURITY NUMBER: 214-07-1725	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 81 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): May 22, 1914	8. BIRTHPLACE (State or Foreign Country): W.Va.
9a. FACILITY NAME (If not institution, give street and number): Frostburg Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: Frostburg		9c. COUNTY OF DEATH: Allegany
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Frostburg		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 11517 Bland Avon Road		10f. ZIP CODE: 21532		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9 / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Pipefitter		16b. KIND OF BUSINESS/INDUSTRY: Ballistics Laboratory	
17. FATHER'S NAME (First, Middle, Last): Albert Ark		18. MOTHER'S NAME (First, Middle, Maiden Surname): Fannie Boyard		
19a. INFORMANT'S NAME (Type/Print): Sandra Chapman	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11801 Old Legislative Rd. S.W., Frostburg, Md. 21532			
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Rest Lawn Memorial Gdns DATE: 6/12		20c. LOCATION — City or Town, State: La Vale, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John P. Horn	22. NAME AND ADDRESS OF FACILITY: 57 Frost Ave. Durst Funeral Home, Frostburg, Md. 21532			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	(Poss) Pulmonary Embolism.	10 minutes
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b.	Venous Thrombosis	Unknown
DUE TO (OR AS A CONSEQUENCE OF): c.		
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular accident with left hemiplegia
Depression. Hypertension hyperthyroidism

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one):
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
S.L. Sandhir M.D.	D 14464	6/12/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): S.L. Sandhir, M.D., 48 Tarn Terrace, Frostburg, Md. 21532

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 13 1995	[illegible] Davidson-Randall

5

DHMH-16 Rev 1/89

95 20002

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Gertrude Alleva					2. DATE OF DEATH (Month, Day, Year): June 15, 1995	3. TIME OF DEATH: 915 pM
4. SOCIAL SECURITY NUMBER: 100-34-1007	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 77 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): March 13, 1918	8. BIRTHPLACE (State or Foreign Country): Poland
9a. FACILITY NAME (If not institution, give street and number): Montgomery General Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Olney			9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Rockville	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 15016 Rocking Spring Drive		10f. ZIP CODE: 20853	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): –	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Owner	16b. KIND OF BUSINESS/INDUSTRY: Luncheonette	
17. FATHER'S NAME (First, Middle, Last): Hymon Likier		18. MOTHER'S NAME (First, Middle, Maiden Surname): Yetta Levine	
19a. INFORMANT'S NAME (Type/Print): Gerald Alleva		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15016 Rocking Spring Drive, Rockville, MD 20853	
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Ferncliff Cemetery DATE: June 18, 1995	20c. LOCATION — City or Town, State: Hartsdale, New York	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Richard G. Kuttler M00348	22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 W. Montgomery Ave Rockville, Maryland 20850-2805		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Ovarian Cancer	One Year
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
MD	D33686	June 15, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Kenneth Miller, MD 18111 Prince Phillip Dr. Olney, MD 20832

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 19 1995	Julia Davidson Randall

DHMH-16 Rev 1/89

95-3421-037
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95 20003

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOSEPH FRANCIS ABELL		2. DATE OF DEATH (Month, Day, Year): JUNE 11 1995	3. TIME OF DEATH: 5:30 AM
4. SOCIAL SECURITY NUMBER: 218-15-6614	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 23 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): September 6, 1971
8. BIRTHPLACE (State or Foreign Country): Maryland			
9a. FACILITY NAME (If not institution, give street and number): PATUXENT RIVER	9b. CITY, TOWN OR LOCATION OF DEATH: Patuxent River	9c. COUNTY OF DEATH: ST.MARYS	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: St. Mary's	10c. CITY, TOWN OR LOCATION: Leonardtown	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: Star Route Box 22 B 3	10f. ZIP CODE: 20650	10g. CITIZEN OF WHAT COUNTRY?: United States	
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5 +): 1	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Road Manager	16b. KIND OF BUSINESS/INDUSTRY: Musical Band	
17. FATHER'S NAME (First, Middle, Last): Francis Eugene Abell	18. MOTHER'S NAME (First, Middle, Maiden Surname): Deborah Anne Shlemon		
19a. INFORMANT'S NAME (Type/Print): Deborah S. Lopitz	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Star Route Box 22 B 3, Leonardtown, Maryland 20650		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan Crematory DATE: 6/15	20c. LOCATION — City or Town, State: Alexandria, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Edward N. Brinsfield, Jr. M00052	22. NAME AND ADDRESS OF FACILITY: BRINSFIELD FUNERAL HOME NORTH WASHINGTON ST. LEONARDTOWN, MD		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	e. DROWNING	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) PATUXENT RIVER

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28e. DATE OF INJURY (Month, Day, Year): 05/27/95	28b. TIME OF INJURY: 1:19 AM	28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO	28d. DESCRIBE HOW INJURY OCCURED: Jumped From bridge
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Patuxent River			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Thomas Johnson Bridge Solomons Island

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
[XX] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Dennis J Chute	29c. LICENSE NUMBER: O.C.M.E.	29d. DATE SIGNED (Month, Day, Year): JUNE11,1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201

31. DATE FILED (Month, Day, Year): JUN 20 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

95 20004

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Suzanne Elizabeth BRANTNER				2. DATE OF DEATH (Month, Day, Year): June 23, 1995	3. TIME OF DEATH: 3:40 P.M.
4. SOCIAL SECURITY NUMBER: 146-32-8584	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 53 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Sept. 11, 1941	8. BIRTHPLACE (State or Foreign Country): Canada
9a. FACILITY NAME (If not institution, give street and number): 18701 Printz Road			9b. CITY, TOWN OR LOCATION OF DEATH: Boonsboro		9c. COUNTY OF DEATH: Washington

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Boonsboro	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 18701 Printz Road		10f. ZIP CODE: 21713	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0-12; College (1-4 or 5+): 1-2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): waitress	16b. KIND OF BUSINESS/INDUSTRY: restaurant
17. FATHER'S NAME (First, Middle, Last): unknown		18. MOTHER'S NAME (First, Middle, Maiden Surname): Helen Kieth Rizk	
19a. INFORMANT'S NAME (Type/Print): Mr. Jack E. Brantner		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18701 Printz Road, Boonsboro, Maryland 21713	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Rest Haven Cemetery; DATE: 6-26-95	20c. LOCATION — City or Town, State: Hagerstown, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Scott Minnick		22. NAME AND ADDRESS OF FACILITY: Minnich Funeral Home, 415 East Wilson Blvd., Hagerstown, MD 21740	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or haert failure. List only ona cause on aach line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic rectal cancer. DUE TO (OR AS A CONSEQUENCE OF):	6 months
Sequantially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Diseese or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in tha underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE DF OEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEOICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF OEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	M		

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to tha cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Hind Hamdan MD	DH6473	▶ 6/26/95

30. NAME AND AODRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 363 S. Cleveland Ave., Suite 201; Hagerstown, MD 21740

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 2 - 1995	Julie Shaffer-Rockell

OHMH-18 Rev 1/89

95 20005

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEOENT'S NAME (First, Middle, Last): DOROTHY MAY (KING) BAUER
2. DATE OF DEATH (Month, Day, Year): June 22, 1995
3. TIME OF DEATH: 5:59 A. M
4. SOCIAL SECURITY NUMBER: 214-07-5735
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 86 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): May 15, 1909
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): 611 SYLVAN AVENUE
9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND
9c. COUNTY OF DEATH: ALLEGANY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: ALLEGANY
10c. CITY, TOWN OR LOCATION: CUMBERLAND
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 611 SYLVAN AVENUE
10f. ZIP CODE: 21502
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. OECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4 or 5 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER
16b. KIND OF BUSINESS/INDUSTRY: HOME
17. FATHER'S NAME (First, Middle, Last): WILLIAM KING
16. MOTHER'S NAME (First, Middle, Maiden Surname): ELMIRA RICE
19a. INFORMANT'S NAME (Type/Print): BONNIE BAUER FISHER
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 611 SYLVAN AVE.-CUMBERLAND, MD 21502
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place): HILLCREST BURIAL PARK — DATE: 6/24/95
20c. LOCATION — City or Town, State: CUMBERLAND, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Wendy D. Upchurch
22. NAME AND ADDRESS OF FACILITY: GEORGE-UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition resulting in death) →	a. ARTERIOSCLEROTIC HEART DISEASE	9 yrs.
	DUE TO (OR AS A CONSEOUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEOUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEOUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuee given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Paul Snow
29c. LICENSE NUMBER: D09157
29d. DATE SIGNED (Month, Day, Year): ▶ June 22, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Paul Snow, M.D.-Deputy M.E.-124 W. Third St., Cumberland, MD 21502
31. DATE FILED (Month, Day, Year): JUN 23 1995
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

6

95 20006

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
PAUL	WILLIAM	BOSLET	JUNE 18, 1995	12:45 AM

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
705-05-4738	1 [X] M 2 [ ] F	85 YRS.			Jan 28, 1910	PA

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Memorial Hospital	Cumberland	Allegany

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MD	Allegany	Cumberland	1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
Seton Drive	21502	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] YES 2 [ ] NO — WW II	1 [ ] YES 2 [X] NO Specify:	Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12		Retired Pipefitter	Railroad

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Henry J. Boslet	Mary (Howe)

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mary Seib	Seton Drive; Cumberland, MD 21502

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Rocky Gap Veterans Cem	06/20	Flintstone, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ James F Scarpelli	Scarpelli Funeral Home Cumberland, MD 21502

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pneumonia	4 weeks
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia
Schizophrenia

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [✓]

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [✓] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	28. PLACE OF DEATH (Check only one)	
1 [ ] YES 2 [ ] NO	HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] YES 2 [ ] NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
H.C. Merrick	D 28910	▶ June 19, 95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. H.C. Merrick Memorial Hospital Medical Bldg. Cumberland, MD 21502

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 20 1995	

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DHMH-16 Rev 1/89

95 20007

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Benjamin N. Beeman		2. DATE OF DEATH: Month June, Day 15, Year 1995	3. TIME OF DEATH: 9:20 AM
4. SOCIAL SECURITY NUMBER: 215-64-1880	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 91 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): April 11, 1904
8. BIRTHPLACE (State or Foreign Country): Maryland			
9a. FACILITY NAME (If not institution, give street and number): Goodwill Mennonite Home	9b. CITY, TOWN OR LOCATION OF DEATH: Grantsville	9c. COUNTY OF DEATH: Garrett	
RESIDENCE OF DECEDENT			
10a. STATE: Maryland	10b. COUNTY: Garrett	10c. CITY, TOWN OR LOCATION: Grantsville	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: P.O. Box 310	10f. ZIP CODE: 21536	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Never Worked	16b. KIND OF BUSINESS/INDUSTRY: Invalid	
17. FATHER'S NAME (First, Middle, Last): Noah J. Beeman	18. MOTHER'S NAME (First, Middle, Maiden Surname): Jessie Bennett		
19a. INFORMANT'S NAME (Type/Print): Sara Frankenberry	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 231 Centennial Street Frostburg, Maryland 21532		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Fbg. Memorial Park DATE: June 17,95	20c. LOCATION — City or Town, State: Frostburg, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John R. Durst	22. NAME AND ADDRESS OF FACILITY: Durst Funeral Home 57 Frost Avenue Frostburg, Maryland 21532		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Fatal Ventricular arrhythmia	1 min.
DUE TO (OR AS A CONSEQUENCE OF): b.	Coronary Artery Disease	10 yr.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	Arteriosclerotic Vascular Disease	95 yr.
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia
Diabetes mellitus

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: James E Beitzel MD	29c. LICENSE NUMBER: D 34079	29d. DATE SIGNED (Month, Day, Year): June 15, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James E Beitzel MD Grantsville MD. 21536		
31. DATE FILED (Month, Day, Year): JUN 19 1995	32. REGISTRAR'S SIGNATURE: Linda Bruchey Kendall	

DHMH-18 Rev 1/89

95 20008

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CATHERINE JANE BUCY
2. DATE OF DEATH (Month, Day, Year): JUNE 11, 1995
3. TIME OF DEATH: 10:55 A M
4. SOCIAL SECURITY NUMBER: 214-12-3078
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 96 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): Apr 13, 1899
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND
9c. COUNTY OF DEATH: ALLEGANY

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Allegany
10c. CITY, TOWN OR LOCATION: LaVale
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 10815 Cash Valley Road
10f. ZIP CODE: 21502
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Own Home
17. FATHER'S NAME (First, Middle, Last): John White Campbell
18. MOTHER'S NAME (First, Middle, Maiden Surname): Martha Lidia Rase
19a. INFORMANT'S NAME (Type/Print): Kenneth R. Kinser
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10815 Cash Valley Road; LaVale, MD 21502
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Sunset Memorial Park | DATE: 06/14
20c. LOCATION — City or Town, State: Cumberland, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James J Scarpelli
22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home, Cumberland, MD 21502

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the moda of dying, such as cardiac or reapiratory arreat, ahock, or heart failure. List only one cause on each line.

		Approximate interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cerebro Vascular Accident	2 h
DUE TO (OR AS A CONSEQUENCE OF): b.	Atheselerotic Disease - Hypertension	50 y
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.		
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: History of Colon Cancer

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: R Fadl, M.D
29c. LICENSE NUMBER: 16150
29d. DATE SIGNED (Month, Day, Year): ▶June 11,1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 27 (Type, Print): R. Fadl, M.D.; Seton Drive; Cumberland, MD 21502

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31. DATE FILED (Month, Day, Year): JUN 13 1995
32. REGISTRAR'S SIGNATURE: Gwendolyn Randall

DHMH 16 Rev 1/89

95 20009

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Marie Elizabeth BONNER			2. DATE OF DEATH (Month, Day, Year): June 22 95	3. TIME OF DEATH: 10:40 AM
4. SOCIAL SECURITY NUMBER: 099-18-7336	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 95 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Nov. 16, 1899	8. BIRTHPLACE (State or Foreign Country): New York
9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Kensington	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 9805 Culver Street		10f. ZIP CODE: 20895	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): John Guerin		18. MOTHER'S NAME (First, Middle, Maiden Surname): Jennie Casey	
19a. INFORMANT'S NAME (Type/Print): Walter J. Bonner	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9805 Culver Street, Kensington, MD 20895		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Gate of Heaven Cemetery DATE 6/28/94	20c. LOCATION — City or Town, State: Silver Spring, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Mark C. Willett	22. NAME AND ADDRESS OF FACILITY: Francis J. Collins Funeral Home, Inc. 500 University Blvd.W. Sil.Spr.,MD 20901		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Pneumonia	2 weeks
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Chronic obstructive Pulmonary	
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Disease	4 years
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Fractured left ankle.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year): May 17 95	28b. TIME OF INJURY: — M	28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO	28d. DESCRIBE HOW INJURY OCCURED: Unknown
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Nursing Home.			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Rockville 1237 Potomac Valley

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John Coulter MD	29c. LICENSE NUMBER: D08546	29d. DATE SIGNED (Month, Day, Year): June 22 95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John Coulter MD 8218 Wisconsin Ave Bethesda		
31. DATE FILED (Month, Day, Year): JUN 23 1995	32. REGISTRAR'S SIGNATURE: Julia Brooks-Kendall	

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DHMH-18 Rev 1/89

95 20010

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EDWARD KRUG BENDER					2. DATE OF DEATH (Month, Day, Year): June 19. 1995	3. TIME OF DEATH: 1:52 P. M
4. SOCIAL SECURITY NUMBER: 189-07-2937	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 75 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Nov. 2, 1919	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): 506 Midland Road,			9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring		9c. COUNTY OF DEATH: Montgomery	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Silver Spring	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 506 Midland Road		10f. ZIP CODE: 20904	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: W.W.II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4 or 5+): 5+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Agriculturalist	16b. KIND OF BUSINESS/INDUSTRY: Agric. Chemicals	
17. FATHER'S NAME (First, Middle, Last): Mervin E. Bender		18. MOTHER'S NAME (First, Middle, Maiden Surname): Martha Krug	
19a. INFORMANT'S NAME (Type/Print): Naomi Bender	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 506 Midland Road, Silver Spring, Maryland 20904		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Olivet Cemetery DATE: 6/23/95	20c. LOCATION — City or Town, State: Hanover, Pennsylvania	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Thomas Guyon	22. NAME AND ADDRESS OF FACILITY: Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, Maryland 20904		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arreat, shock, or heart failure. List only one ceuse on eech line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition resulting in death) →	a. CeRebAl Vascular Incedent (Stroke)	5days
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentielly list conditions, if any, leeding to immediete cause. Enter UNDERLYING CAUSE (Disease or injury thet initiated events resulting in death) LAST	b. Essential Hypertension	15yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Diabetes Mellitus	10 yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

olfactory Groove Encavingioma (5 years ago)

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Max G. Sherer MD	29c. LICENSE NUMBER: D0 58832 MD	29d. DATE SIGNED (Month, Day, Year): ▶ 6/19/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MAX G. SHERER MD 800 PERSHING Drive Silver Spring, Md 20910		
31. DATE FILED (Month, Day, Year): JUN 23 1995	32. REGISTRAR'S SIGNATURE: Julia Dudley Rucker	

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DHMH-16 Rev 1/89

95 20011

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): SHIRLEY BRUMMEL			2. DATE OF DEATH: MONTH JUNE DAY 20, YEAR 1995	3. TIME OF DEATH: 10:00 PM M
4. SOCIAL SECURITY NUMBER: 055-01-3361	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): JUNE 8, 1919	8. BIRTHPLACE (State or Foreign Country): NEW YORK
9a. FACILITY NAME (If not institution, give street and number): MONTGOMERY GENERAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: OLNEY		9c. COUNTY OF DEATH: MONTGOMERY
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: SILVER SPRING		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3227 BEL PRE ROAD		10f. ZIP CODE: 20906		10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): BOOKKEEPER		16b. KIND OF BUSINESS/INDUSTRY: AEROSPACE
17. FATHER'S NAME (First, Middle, Last): BERNARD BARASH			18. MOTHER'S NAME (First, Middle, Maiden Surname): MOLLIE KOLLISH	
19a. INFORMANT'S NAME (Type/Print): DONNA OTTONE (DAUGHTER)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17005 OLDE MILL RUN - ROCKVILLE, MARYLAND 20855		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): JUDEAN MEMORIAL GARDENS DATE 6/22		20c. LOCATION — City or Town, State: OLNEY, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Frank A Stone		22. NAME AND ADDRESS OF FACILITY: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE - ROCKVILLE, MD. 20852		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. MULTIPLE ORGAN FAILURE	DAYS.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. OUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic renal failure, liver failure — Chronic, Diabetec mellitus, Pancreatic cancer

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURED
			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	D30457	▶ 6/21/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): NAKUL GOYAL MD, 18311 PRINCE PHILIP DR, OLNEY, MD 20832

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 23 1995	Julie Davidson Randall

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DHMH-18 Rev 1/89

95 20012

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): FREDERICK J. BOND			2. DATE OF DEATH (Month, Day, Year): JUNE 22, 1995	3. TIME OF DEATH: 1:05 A M
4. SOCIAL SECURITY NUMBER: 220-12-3392	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 68 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): SEPT. 3, 1926	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): MEDLANTIC MANOR		9b. CITY, TOWN OR LOCATION OF DEATH: LAYHILL		9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: SILVER SPRING	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1313 BRIGGS CHANEY ROAD		10f. ZIP CODE: 20905	10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: 1944-1946	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 3	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MANAGEMENT	16b. KIND OF BUSINESS/INDUSTRY: TELEPHONE	
17. FATHER'S NAME (First, Middle, Last): JOSEPH W. BOND		18. MOTHER'S NAME (First, Middle, Maiden Surname): JESSIE JOHNSON	
19a. INFORMANT'S NAME (Type/Print): CATHERINE E. BOND		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1313 BRIGGS CHANEY ROAD SILVER SPRING, MD. 20905	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): GATE OF HEAVEN DATE: 6/26/95	20c. LOCATION — City or Town, State: SILVER SPRING, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Muriel H. Barber		22. NAME AND ADDRESS OF FACILITY: MURIEL H. BARBER FUNERAL HOME 20882 P.O. BOX 5038 LAYTONSVILLE, MARYLAND	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. UROSEPSIS		TERM.
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.		
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d. ALZHEIMERS DEMENTIA		4 YRS

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PRIOR C.V.A.
C.O.P.D.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	26a. DATE OF INJURY (Month, Day, Year) / 26b. TIME OF INJURY M / 26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 26d. DESCRIBE HOW INJURY OCCURED	
	26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Donald R. Lewis MD	29c. LICENSE NUMBER: D06406	29d. DATE SIGNED (Month, Day, Year): ▶ JUNE 22, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DONALD R. LEWIS MD OLNEY, MD 20832		
31. DATE FILED (Month, Day, Year): JUN 23 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

15+1

OHMH-16 Rev 1/89

95 20013

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): James Artie Bowersox, Jr.			2. DATE OF DEATH (Month, Day, Year): June 20, 1995	3. TIME OF DEATH: 1604 M
4. SOCIAL SECURITY NUMBER: 218-40-8407	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 51 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): April 13, 1944
8. BIRTHPLACE (State or Foreign Country): Maryland				

9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Medical Center	9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis	9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Washington Grove	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: P.O. Box 1097 - 103 Grove Avenue		10f. ZIP CODE: 20880	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 5+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Systems Manager	16b. KIND OF BUSINESS/INDUSTRY: Bell Atlantic Telephone Co.

17. FATHER'S NAME (First, Middle, Last): James Artie Bowersox, Sr.	18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Louise Pacy
19a. INFORMANT'S NAME (Type/Print): Evelyn M. Bowersox	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 1097 - 103 Grove Ave., Wash. Grove, MD 20880

20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan Crematory	DATE: 6/24	20c. LOCATION — City or Town, State: Alexandria, Virginia
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]	22. NAME AND ADDRESS OF FACILITY: DeVol Funeral Home, 10 E. Deer Park Dr., Gaithersburg, MD 20877		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Myocardial Insufficiency	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): b. ASCVD	
	DUE TO (OR AS A CONSEQUENCE OF): c. Hypercholesterolemia.	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: William R. Jones MD Deputy	29c. LICENSE NUMBER: D06054	29d. DATE SIGNED (Month, Day, Year) ▶ 6/20/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): William R. Jones, MD 695 Amerila 21035		
31. DATE FILED (Month, Day, Year): JUN 23 1995	32. REGISTRAR'S SIGNATURE: Julia Hamilton Randall	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Item19a 8-18-95 filmG726 W.H.Per F/H

95 20014

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Bertha M. Burgess
2. DATE OF DEATH (Month, Day, Year): June 20 1995
3. TIME OF DEATH: 625 A.M.
4. SOCIAL SECURITY NUMBER: 213-34-1167
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (in yrs. last birthday): 89 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Dec 20, 1905
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Howard County General Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Columbia
9c. COUNTY OF DEATH: Howard

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Howard
10c. CITY, TOWN OR LOCATION: Ellicott City
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 13126 Tridelphia Road
10f. ZIP CODE: 21042
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5th Grade; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KIND OF BUSINESS/INDUSTRY: None
17. FATHER'S NAME (First, Middle, Last): Richard Estep
18. MOTHER'S NAME (First, Middle, Maiden Surname): Carrie Wise
19a. INFORMANT'S NAME (Type/Print): (Son) Mr Vernon ~~Wise~~ Burgess
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13170 Tridelphia Rd, Ellicott City, Md (21042)
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Crestlawn Memorial Cem DATE 6/24
20c. LOCATION — City or Town, State: Marriottsville, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: George R. Snowden
22. NAME AND ADDRESS OF FACILITY: Snowden Funeral Home P.A. 20850 246 N. Washington St. Rockville, Md

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	cerebral vascular Accident	7 days
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Hypertension	20 years
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: diabetes mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year): N/A
28b. TIME OF INJURY: N/A M
28c. INJURY AT WORK? N/A 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED: N/A
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): N/A

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Allen Funic MD
29c. LICENSE NUMBER: D43219
29d. DATE SIGNED (Month, Day, Year): ▶ June 20 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Allen Funic MD. 2 Kendall Dr. Columbia MD 21045
31. DATE FILED (Month, Day, Year): JUN 22 1995
32. REGISTRAR'S SIGNATURE: [illegible]

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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95 20015

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARGARET CATHERINE BERGER			2. DATE OF DEATH (Month, Day, Year): JUNE 20, 1995	3. TIME OF DEATH: 7:00 A M
4. SOCIAL SECURITY NUMBER: 579-52-4656	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 83 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 22, 1912	8. BIRTHPLACE (State or Foreign Country): New York
9a. FACILITY NAME (If not institution, give street and number): 1316 Nicholson Street		9b. CITY, TOWN OR LOCATION OF DEATH: Hyattsville		9c. COUNTY OF DEATH: Prince George

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George	10c. CITY, TOWN OR LOCATION: Hyattsville	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1316 Nicholson Street		10f. ZIP CODE: 20782-1512	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Administrative Assistant	16b. KIND OF BUSINESS/INDUSTRY: Education	
17. FATHER'S NAME (First, Middle, Last): Thomas E. Ryan		18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret McHugh	
19a. INFORMANT'S NAME (Type/Print): Ralph C. Berger	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1316 Nicholson Street, Hyattsville, Maryland 20782		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Fort Lincoln Crematory	DATE: 6/23	20c. LOCATION — City or Town, State: Brentwood, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert T. Smith	22. NAME AND ADDRESS OF FACILITY: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Hypertensive Heart Disease DUE TO (OR AS A CONSEQUENCE OF):	(Less than) 6 Months
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Essential Hypertension DUE TO (OR AS A CONSEQUENCE OF):	Years
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO NA

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): NA	28b. TIME OF INJURY: M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29e. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John F. Brennan MD	29c. LICENSE NUMBER: D03606	29d. DATE SIGNED (Month, Day, Year): June 20, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		
31. DATE FILED (Month, Day, Year): JUN 22 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

6

95 20016

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WILLIAM Pierce BROWN			2. DATE OF DEATH (Month, Day, Year): June 19 1995	3. TIME OF DEATH: 9:45A M
4. SOCIAL SECURITY NUMBER: 219 42 4998	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 84 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Aug. 8, 1910
8. BIRTHPLACE (State or Foreign Country): North Carolina				

9a. FACILITY NAME (If not institution, give street and number): Suburban Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda	9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Bethesda	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 8910 Ridge Place	10f. ZIP CODE: 20817		10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: World War II	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): - ; College (1-4 or 5+): 5+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Lawyer	16b. KIND OF BUSINESS/INDUSTRY: State Department	
17. FATHER'S NAME (First, Middle, Last): William Brown		18. MOTHER'S NAME (First, Middle, Maiden Surname): Alice Mangan	
19a. INFORMANT'S NAME (Type/Print): William P. Brown	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 821 Nicodemus Road, Reisterstown, Maryland 21136		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Gate of Heaven Cemetery; DATE: June 22, 1995	20c. LOCATION — City or Town, State: Silver Spring, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] M00689	22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, MD 20814-3501		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiac Arrest	10 mins
DUE TO (OR AS A CONSEQUENCE OF):	b. Ventricular Arrythmia	1/2 hr
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c. Coronary Arteriosclerotic Heart Disease	1 year
DUE TO (OR AS A CONSEQUENCE OF):	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D-11031	29d. DATE SIGNED (Month, Day, Year): 6-20-95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Joseph J. Wallace, M.D. 5272 River Road #340, Bethesda, Maryland 20816-1478

31. DATE FILED (Month, Day, Year): JUN 22 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

60+1

95 20017

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Philip F. Bowers			2. DATE OF DEATH (Month, Day, Year): June 18, 1995	3. TIME OF DEATH: 4:30 P M
4. SOCIAL SECURITY NUMBER: 577-12-6747	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 73 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): April 4,1922	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): 2301 Stratton Drive		9b. CITY, TOWN OR LOCATION OF DEATH: Potomac		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Potomac	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 2301 Stratton Drive		10f. ZIP CODE: 20854	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: World War II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): – ; College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Personnel Manager	16b. KIND OF BUSINESS/INDUSTRY: Bell Atlantic	
17. FATHER'S NAME (First, Middle, Last): Karl Bowers		18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret Kelsch	
19a. INFORMANT'S NAME (Type/Print): Hester D. Bowers	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2301 Stratton Drive, Potomac, Maryland 20854		
20a. METHOD OF DISPOSITION: [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Gate of Heaven Cemetery DATE: June 21, 1995	20c. LOCATION — City or Town, State: Silver Spring,Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michele O. Kutta M00348	22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 W. Montgomery Ave Rockville, Maryland 20850-2805		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Prostate Cancer	4½ years
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [X]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Bruce R. Kressel M.D.	29c. LICENSE NUMBER: D23600	29d. DATE SIGNED (Month, Day, Year): ▶ June 19, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Bruce R. Kressel, M.D. 5480 Wisconsin Avenue, #214 Chevy Chase, MD 20815-3552		
31. DATE FILED (Month, Day, Year): JUN 21 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall	

DHMH-16 Rev 1/89

25 x 1

95 20018

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): PAUL EMILE BURNS
2. DATE OF DEATH: MONTH June DAY 13 YEAR 1995
3. TIME OF DEATH: 8:13 AM
4. SOCIAL SECURITY NUMBER: 002-18-0523
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 76 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Aug. 26, 1918
8. BIRTHPLACE (State or Foreign Country): New Hampshire
9a. FACILITY NAME (If not institution, give street and number): Washington Adventist Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Takoma Park
9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Prince Georges
10c. CITY, TOWN OR LOCATION: Adelphi
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 9717 Riggs Road
10f. ZIP CODE: 20783
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES: 1942 - 1945
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+): 4
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Mechanical Engineer
16b. KIND OF BUSINESS/INDUSTRY: Federal Government
17. FATHER'S NAME (First, Middle, Last): Henry Burns
18. MOTHER'S NAME (First, Middle, Maiden Surname): Laura Fortin
19a. INFORMANT'S NAME (Type/Print): Edwarda Burns
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9717 Riggs Road, Adelphi, Maryland 20783
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Gate of Heaven Cemetery | DATE: 6/16
20c. LOCATION — City or Town, State: Silver Spring, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Lani Trent-Holland
22. NAME AND ADDRESS OF FACILITY: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis. Shock (Cardiorespiratory)

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Pneumonia, Cardiorespiratory arrest

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

D.M. HTN

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M. Saeed Koolaee, M.D.
29c. LICENSE NUMBER: D46260
29d. DATE SIGNED (Month, Day, Year): 6/13/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): M. SAEED KOOLAEE. 6188 OXON HILL RD, OXON HILL, MD

31. DATE FILED (Month, Day, Year): JUN 19 1995
32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall

DHMH-16 Rev 1/89

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95 20019

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Carol Marie Brophy			2. DATE OF DEATH: Month June, Day 17, Year 1995	3. TIME OF DEATH: 1:50 A M
4. SOCIAL SECURITY NUMBER: 220-40-3190	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 52 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Sept.5,1942	8. BIRTHPLACE (State or Foreign Country): Washington,D.C.
9a. FACILITY NAME (If not institution, give street and number): 3208 Hitchcock Court		9b. CITY, TOWN OR LOCATION OF DEATH: Olney		9c. COUNTY OF DEATH: Montgomery
RESIDENCE OF DECEDENT				
10a. STATE: California	10b. COUNTY: Los Angeles	10c. CITY, TOWN OR LOCATION: Manhattan Beach		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 552 Second Street		10f. ZIP CODE: 90266		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: Vietnam	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 5+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Aerospace Engineer		16b. KIND OF BUSINESS/INDUSTRY: Aerospace
17. FATHER'S NAME (First, Middle, Last): Charles Andrew Brophy			18. MOTHER'S NAME (First, Middle, Maiden Surname): Josephine Anne Martin	
19a. INFORMANT'S NAME (Type/Print): Mary Brophy Haddow		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3208 Hitchcock Court Olney, Maryland 20832		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Holy Cross Cemetery DATE: 6/23/95	20c. LOCATION — City or Town, State: Culver City,California		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Steven J Stroud	22. NAME AND ADDRESS OF FACILITY: Francis J. Collins Funeral Home, Inc. 500 University Blvd.,W. Sil.Spr.,MD 20901			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Lung Cancer	1 Year
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
DUE TO (OR AS A CONSEQUENCE OF):		
	c.	
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☒ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD

29c. LICENSE NUMBER: D 29675

29d. DATE SIGNED (Month, Day, Year): ▶ June 19,1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ralph Boccia, M.D. 9707 Medical Center Drive Rockville,Maryland 20850

31. DATE FILED (Month, Day, Year): JUN 20 1995

32. REGISTRAR'S SIGNATURE: [signature]

OHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20+1

95 20020

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GILBERT FRANCIS BEAVERS
2. DATE OF DEATH (Month, Day, Year): June 20, 1995
3. TIME OF DEATH: 2:00 P M
4. SOCIAL SECURITY NUMBER: 215-18-0449
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 73 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): May 24, 1922
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 2400 Philadelphia Rd.
9b. CITY, TOWN OR LOCATION OF DEATH: Edgewood
9c. COUNTY OF DEATH: Harford

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Harford
10c. CITY, TOWN OR LOCATION: Edgewood
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 2400 Philadelphia Rd.
10f. ZIP CODE: 21040
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WWII
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Building Contractor
16b. KIND OF BUSINESS/INDUSTRY: Construction
17. FATHER'S NAME (First, Middle, Last): Sampson Wallace Beavers
18. MOTHER'S NAME (First, Middle, Maiden Surname): Nellie (nmn) Tillet
19a. INFORMANT'S NAME (Type/Print): Louise L. Beavers
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2400 Philadelphia Rd., Edgewood, Md. 21040
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Bel Air Memorial Gardens — DATE: 6-23-95
20c. LOCATION — City or Town, State: Bel Air, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Howard K McComas III
22. NAME AND ADDRESS OF FACILITY: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Md. 21040

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Ischemic Heart Disease	
DUE TO (OR AS A CONSEQUENCE OF): b.	Ventricular Tachycardia	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.		
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Joseph Reinhardt
29c. LICENSE NUMBER: D15673
29d. DATE SIGNED (Month, Day, Year): 6/27/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Joseph Reinhardt MD - 2003 Rock Spring Rd, Forest Hill, MD 21050
31. DATE FILED (Month, Day, Year): JUN 22 1995
32. REGISTRAR'S SIGNATURE: Julia Dawson-Randall

DHMH-16 Rev 1/89

RKD

95-3602-005

ITEMS: 28a-f, PER MEO FILM G-726 8/24/95 t.t

ITEMS: 18. & 19a, PER F.H. 23 PART I, 27, PER MEO FILM G-725 7/3/95 t.t

95 20021

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month / Day / Year)	3. TIME OF DEATH
MICHAEL	ALAN	CARRIER	JUNE 20 95	1:45 P.M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
213-78-1872	1 [X] M 2 [ ] F	36 YRS.			Sept. 18, 1958	Pennsylvania

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
10100 YORK ROAD	COCKEYSVILLE	BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Baltimore	Parkton	1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
1801 Mount Carmel Road	21120	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] YES 2 [X] NO	1 [ ] YES 2 [X] NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12		Plumber	Plumbing

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
William W. Carrier, II	Kathleen ~~Carrier~~ J. GARRETY

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Kathleen ~~Carrier~~ CARRIER	1801 Mount Carmel Rd., Parkton, MD 21120

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Yorktowne Caskets, Inc. Cremation Serv.	June 25, 1995	York, PA 17404

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ J. J. Hartenstein	J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. NARCOTIC INTOXICATION	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [X] YES 2 [ ] NO	1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [X] YES 2 [ ] NO	HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) MOTEL ROOM

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [X] Could not be determined	FOUND 6/20/95	UNKNOWN M	1 [ ] YES 2 [X] NO	UNKNOWN

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
FOUND HOTEL	10100 YORK ROAD

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[illegible]	O.C.M.E.	▶ JUNE 21,1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
[illegible] 111 Penn Street, Baltimore, Maryland 21201

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 28 1995	[illegible]

DHMH-16 Rev 1/89

95 20022

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARKEL CUSICK MN - NAJEE			2. DATE OF DEATH (Month, Day, Year): JUNE 17, 1995	3. TIME OF DEATH: 12:44P M
4. SOCIAL SECURITY NUMBER: 215-43-6096	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS 6, DAYS 11 — IF UNDER 24 HRS.: HOURS, MIN.	7. DATE OF BIRTH (Month, Day, Year): Dec. 6, 1994	8. BIRTHPLACE (State or Foreign Country): D. C.
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Prince Georges	10c. CITY, TOWN OR LOCATION: Forestville	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1900 Ritchie Road		10f. ZIP CODE: 20747	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0; College (1-4 or 5+):	18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): NA	16b. KIND OF BUSINESS/INDUSTRY: NA	
17. FATHER'S NAME (First, Middle, Last): Kelvin M. Cusick		18. MOTHER'S NAME (First, Middle, Maiden Surname): Marcella A. Horton	
19a. INFORMANT'S NAME (Type/Print): Marcella A. Cusick		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1900 Ritchie Rd., Mitchellville, Md. 20747	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place): George Washington Cem. DATE: 6/24/95	20c. LOCATION — City or Town, State: Adelphi, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ R. N. Horton		22. NAME AND ADDRESS OF FACILITY: R. N. Horton Co. Morticians, Inc. 600 Kennedy St., N. W., Wash., D. C.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Pulmonary Hemorrage	30 min
DUE TO (OR AS A CONSEQUENCE OF): b.	Multiple Organ System Failure	7 Days
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	Hepatic Failure	months
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [X] YES 2 [ ] NO	1 [ ] YES 2 [X] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D42485	29d. DATE SIGNED (Month, Day, Year) ▶ 6/7/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Johns Hopkins Hospital 600 Wolfe Street Baltimore, MD		
31. DATE FILED (Month, Day, Year): JUL 03 1995	32. REGISTRAR'S SIGNATURE: [signature]	

DHMH-16 Rev 1/89

95 20023

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ethel Virginia Campbell				2. DATE OF DEATH (Month, Day, Year): 6 26 95	3. TIME OF DEATH: 6:00 AM
4. SOCIAL SECURITY NUMBER: 212-38-8619	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 56 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 9/10/38	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 312 N. Prospect St.			9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown		9c. COUNTY OF DEATH: Washington

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Hagerstown	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 312 N. Prospect St.		10f. ZIP CODE: 21740	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Machine Operator	16b. KIND OF BUSINESS/INDUSTRY: Automotive	
17. FATHER'S NAME (First, Middle, Last): Godfrey Carter		18. MOTHER'S NAME (First, Middle, Maiden Surname): Coretta Thornton Carter	
19a. INFORMANT'S NAME (Type/Print): William A. Campbell Sr.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 312 N. Prospect ST Hagerstown, MD 21740	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Rose Hill Cemetery DATE: 7/1/95	20c. LOCATION — City or Town, State: Hagerstown, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Thomas E. Watts		22. NAME AND ADDRESS OF FACILITY: Watsons FH 21740 24 W. Bethel St. Hagerstown, MD.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Small cell Carcinoma of	7 months
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): b. lung	
	DUE TO (OR AS A CONSEQUENCE OF): c.	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Frederick H. Gass III MD	29c. LICENSE NUMBER: D23623	29d. DATE SIGNED (Month, Day, Year): ▶ 6/27/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Frederick H. Gass III MD 1799 Howell Rd Hagerstown Md		
31. DATE FILED (Month, Day, Year): JUN 2 6 1995	32. REGISTRAR'S SIGNATURE: Julia Baker Reed	

DHMH-18 Rev 1/89

95 20024

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ELIZABETH Allen CHAPMAN		2. DATE OF DEATH (Month, Day, Year): JUNE 26 1995	3. TIME OF DEATH: 3: 20 P M
4. SOCIAL SECURITY NUMBER: 212-14-7174	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 85 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): June 12, 1910
8. BIRTHPLACE (State or Foreign Country): Virginia			
9a. FACILITY NAME (If not institution, give street and number): Williamsport Nursing Home	9b. CITY, TOWN OR LOCATION OF DEATH: Williamsport	9c. COUNTY OF DEATH: Washington	
RESIDENCE OF DECEDENT			
10a. STATE: Md.	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Hagerstown	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 11119 Hopewell Rd.	10f. ZIP CODE: 21740	10g. CITIZEN OF WHAT COUNTRY? U.S.A	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): Bernard Peyton Allen		18. MOTHER'S NAME (First, Middle, Maiden Surname): Olive Cooper Wallace	
19a. INFORMANT'S NAME (Type/Print): Ellen C. Farrell		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2742 Horseshoe Trail Chester Springs, Pa. 19425	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Smithsburg Crematory 6-27-95	20c. LOCATION — City or Town, State: Smithsburg, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dennis L. Davis		22. NAME AND ADDRESS OF FACILITY: Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CONGESTIVE HEART FAILURE	1 YEAR
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: T.E. Howe. MD	29c. LICENSE NUMBER: D 33700	29d. DATE SIGNED (Month, Day, Year): ▶ JUNE 26, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): TED E. HOWE, M.D., 154 NORTH ARTIZAN STREET, WILLIAMSPORT, MD 21795

31. DATE FILED (Month, Day, Year): JUN 29 1995	SIGNATURE: John [illegible]

OHMH-18 Rev 1/89

Amended #4, 6/23/95, NBS, Allegany Co.

95 20025

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DOLORES Cornelia CAIN			2. DATE OF DEATH — MONTH DAY YEAR: June 23, 1995	3. TIME OF DEATH: 5:25 a M
4. SOCIAL SECURITY NUMBER: 185-24[illegible]3541	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 62 YRS. — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS.: HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year): Sept.7,1932	8. BIRTHPLACE (State or Foreign Country): Penna.
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland		9c. COUNTY OF DEATH: Allegany

RESIDENCE OF DECEDENT

10a. STATE: Pa.	10b. COUNTY: Bedford	10c. CITY, TOWN OR LOCATION: Cumb. Valley Township	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Rt.#3 Box 522 Pine Ridge Rd.		10f. ZIP CODE: 15522	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): Percy Howsare		18. MOTHER'S NAME (First, Middle, Maiden Surname): Bessie Imes	
19a. INFORMANT'S NAME (Type/Print): Charles L. Cain	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt.#3 Box 522 Bedford, Pa. 15522		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Sunset Memorial Park	DATE: June25,95	20c. LOCATION — City or Town, State: Cumberland, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert C. Adams	22. NAME AND ADDRESS OF FACILITY: Merritt-Adams Funeral Home 404 Decatur St. Cumberland, Md. 21502		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. SEPTIC SHOCK	3 DAYS
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. STAPHLOCOCCUS AUREUS BACTEREMIA	3 DAYS
DUE TO (OR AS A CONSEQUENCE OF):		
	c.	
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS
RENAL FAILURE

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) — 28b. TIME OF INJURY M — 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO — 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	26d. DESCRIBE HOW INJURY OCCURED — 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: William Lamm MD	29c. LICENSE NUMBER: D 25406	29d. DATE SIGNED (Month, Day, Year): June23,1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. William Lamm-47 Virginia Avenue-Cumberland, MD 21502		
31. DATE FILED (Month, Day, Year): JUN 23 1995	32. REGISTRAR'S SIGNATURE: [illegible]	

DHMH-16 Rev 1/89

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95 20026

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
Mary Josephine Chipman		June 16, 1995	6:20 A M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
215-18-8179	1 ☐ M 2 ☒ F	73 YRS.			Sept 2, 1921	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Berlin Nursing & Rehab Center	Berlin	Worcester

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Worcester	Girdletree	1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
2836 Snow Hill Road	21829	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12		Product Representative	Appliance Corp.

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
William Webb DeWitt	Verna Speicher

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Harry G. Chipman, Jr.	2836 Snow Hill Rd., Girdletree, MD 21829

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Hoyes Meth. Cemetery,	June 20,95	Friendsville, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ L. Lynn Newman	Newman Funeral Homes, P.A. 179 Miller St., Grantsville, MD 21536

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Myocardial Infarct	5 min
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Coronary Artery Disease	Years
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Diabetes Mellitus - Insulin Dep.	Years
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Senile Dementia
CVA

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
	D02026	▶ June 16, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Federico G. Arthes MD 1622A Ocean Pines Berlin MD 21811

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 23 1995	Marilou Randall

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DHMH-18 Rev 1/89

95 20027

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): John George Canavan			2. DATE OF DEATH (Month, Day, Year): June 20, 1995	3. TIME OF DEATH: 10:00 A M
4. SOCIAL SECURITY NUMBER: 579-18-1254	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 12, 1921	8. BIRTHPLACE (State or Foreign Country): Canada
9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring		9c. COUNTY OF DEATH: Montgomery
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Silver Spring		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 415 Hamilton Avenue		10f. ZIP CODE: 20901		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Electrician	16b. KIND OF BUSINESS/INDUSTRY		
17. FATHER'S NAME (First, Middle, Last): James Andrew Canavan		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Chambers		
19a. INFORMANT'S NAME (Type/Print): Margaret H. Canavan	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 415 Hamilton Avenue Silver Spring,Maryland 20901			
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Gate of Heaven Cemetery	DATE: 6/22/95	20c. LOCATION — City or Town, State: Silver Spring,Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Andrew J. Cole	22. NAME AND ADDRESS OF FACILITY: Francis J. Collins Funeral Home, Inc. 500 University Blvd.,W. Sil.Spr.,MD 20901			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Lung Cancer	2 Months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [X] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Frederick G. Barr	D 22775	June 20, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Frederick G. Barr, M.D. 2101 Medical Park Drive Silver Spring,Maryland 20902

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 22 1995	Julia Davidson-Kendall

DHMH-16 Rev 1/89

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Emeline Cole.

95 20028

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EMELINE THOMPSON COLE			2. DATE OF DEATH (Month, Day, Year): JUNE 18, 1995	3. TIME OF DEATH: 7:30 P M
4. SOCIAL SECURITY NUMBER: 579-22-5423	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 86 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): AUG. 16, 1908	8. BIRTHPLACE (State or Foreign Country): WASHINGTON, D.C.
9a. FACILITY NAME (If not institution, give street and number): MONTGOMERY GENERAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: OLNEY		9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: SILVER SPRING	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 14400 HOMECREST ROAD		10f. ZIP CODE: 20906	10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER	16b. KIND OF BUSINESS/INDUSTRY: OWN HOME	
17. FATHER'S NAME (First, Middle, Last): EDGAR F. THOMPSON		18. MOTHER'S NAME (First, Middle, Maiden Surname): LILLIE M. LUSBY	
19a. INFORMANT'S NAME (Type/Print): JAMES E. STUFFT	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17721 OVERWOOD DRIVE OLNEY, MARYLAND 20832		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): METROPOLITAN CREMATORY DATE: 6/20/95	20c. LOCATION — City or Town, State: ALEXANDRIA, VIRGINIA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Muriel H. Barber	22. NAME AND ADDRESS OF FACILITY: MURIEL H. BARBER FUNERAL HOME 20882 P.O. BOX 5038 LAYTONSVILLE, MARYLAND		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Myocardial Infarction	Minutes
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Ischemic Cardiomyopathy	Months
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Peripheral Vascular Disease

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Phil Henzlum MD Internist	29c. LICENSE NUMBER: D35045	29d. DATE SIGNED (Month, Day, Year): June 19, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PHIL HENZLUM MD 13975 Conn. Ave. #308 Silver Spring, MD 20906		
31. DATE FILED (Month, Day, Year): JUN 21 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

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95 20029

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Paul S. Coolidge		2. DATE OF DEATH (Month, Day, Year): June 15, 1995	3. TIME OF DEATH: 9:25 pm M
4. SOCIAL SECURITY NUMBER: 579-12-1492	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 82 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): March 11,1913 — 8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): 7403 Denton Road		9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda	9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Bethesda	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 7403 Denton Road		10f. ZIP CODE: 20814	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Salesman	16b. KIND OF BUSINESS/INDUSTRY: Appliance Manufacturing Company
17. FATHER'S NAME (First, Middle, Last): Frederick C. Coolidge		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mazie Keeney	
19a. INFORMANT'S NAME (Type/Print): Olive H. Coolidge		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7403 Denton Road Bethesda, Maryland 20814	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mount Olivet Cemetery — DATE: June 17, 1995	20c. LOCATION — City or Town, State: Frederick, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Larry Beckert M00335		22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Congestive Heart Failure	14 Months
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Iscremic Cardimypathy	1992
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Coronary Artery Disease	1989
DUE TO (OR AS A CONSEQUENCE OF):		
d.	Coronary	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Aortic & Mitrual Insufficiency

Ventricular Tachycardia

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: David B. Grossberg MD	29c. LICENSE NUMBER: D36822	29d. DATE SIGNED (Month, Day, Year): June 16, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, print): David Grossberg M.D. 2415 Musgrove Road #307 Silver Spring, Maryland 20904

31. DATE FILED (Month, Day, Year): JUN 19 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

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95 20030

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): George Nevitt Collins		2. DATE OF DEATH (Month, Day, Year): June 24, 1995	3. TIME OF DEATH: 9:55 A M
4. SOCIAL SECURITY NUMBER: 577-60-1205	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Jun 11, 1914
8. BIRTHPLACE (State or Foreign Country): Virginia			
9a. FACILITY NAME (If not institution, give street and number): 87 Palamino Drive	9b. CITY, TOWN OR LOCATION OF DEATH: Hollywood	9c. COUNTY OF DEATH: St. Mary's	
RESIDENCE OF DECEDENT			
10a. STATE: Maryland	10b. COUNTY: St. Mary's	10c. CITY, TOWN OR LOCATION: Hollywood	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Rt. 3 87 Palamino Drive	10f. ZIP CODE: 20636	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th Grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Offset Plate Maker	16b. KIND OF BUSINESS/INDUSTRY: U.S. Government	
17. FATHER'S NAME (First, Middle, Last): John Harry Collins	18. MOTHER'S NAME (First, Middle, Maiden Surname): Lillie Barr		
19a. INFORMANT'S NAME (Type/Print): Carl F. Graff	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7120 Rison Dr., Indian Head, Maryland 20640		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Charles Memorial Gardens	DATE: 6/27/95	20c. LOCATION — City or Town, State: Leonardtown, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Michael K Gardiner	22. NAME AND ADDRESS OF FACILITY: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Suicide - GSW	Sec
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): b. Depression	YRS
	DUE TO (OR AS A CONSEQUENCE OF): c.	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): N/A	28b. TIME OF INJURY: — M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED: —		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): —	

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: William Boyd MD	29c. LICENSE NUMBER: 014285	29d. DATE SIGNED (Month, Day, Year): 6/24/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): William D. Boyd, II, M.D. Leonardtown, Maryland 20650		
31. DATE FILED (Month, Day, Year): JUN 27 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

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95-3456-009

ITEMS: 23 PART II, PER MEO FILM G-726 8/10/95 t.t

95 20031

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): FRANKIE LEILA CRIDER			2. DATE OF DEATH (Month, Day, Year): JUNE 12 1995	3. TIME OF DEATH: 7:30 AM
4. SOCIAL SECURITY NUMBER: 558-54-3937	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 54 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): July 16, 1940	8. BIRTHPLACE (State or Foreign Country): Wasco, California
9a. FACILITY NAME (If not institution, give street and number): CALVERT MEMORIAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: PRINCE FREDERICK		9c. COUNTY OF DEATH: CALVERT
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Calvert	10c. CITY, TOWN OR LOCATION: Lusby		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 11625 Bald Bluff Road		10f. ZIP CODE: 20657		10g. CITIZEN OF WHAT COUNTRY? United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specity Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): - - - -		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife		16b. KIND OF BUSINESS/INDUSTRY: N/A
17. FATHER'S NAME (First, Middle, Last): Henry Witcher		18. MOTHER'S NAME (First, Middle, Maiden Surname): Essie Gray		
19a. INFORMANT'S NAME (Type/Print): Gerald D. Crider		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11625 Bald Bluff Road, Lusby, Maryland 20657		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Ebenezer Cemetery DATE: 6/16/95		20c. LOCATION — City or Town, State: Lexington Park, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Edward N. Brinsfield, Jr. M00052		22. NAME AND ADDRESS OF FACILITY: Brinsfield Funeral Home P.O. Box 279, Leonardtown, Maryland 20650		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DIABETES MELLITUS	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

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24a. WAS AN AUTOPSY PERFORMED? ☒ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: J. Aaron Locke MD	29c. LICENSE NUMBER: O.C.M.E.	29d. DATE SIGNED (Month, Day, Year): ▶ JUNE 13,1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. AARON LOCKE, MD	111 Penn Street, Baltimore, Maryland 21201	
31. DATE FILED (Month, Day, Year): JUN 22 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

95 20032

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HARRY E. CHAPMAN Jr.			2. DATE OF DEATH (Month, Day, Year): JUNE 15 1995	3. TIME OF DEATH: 06:20AM. M
4. SOCIAL SECURITY NUMBER: 054-24-2667	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): April 6, 1914	8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): St. Mary's Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Leonardtown		9c. COUNTY OF DEATH: St. Mary's

RESIDENCE OF DECEDENT

10a. STATE: Virginia	10b. COUNTY: Westmoreland	10c. CITY, TOWN OR LOCATION: Colonial Beach	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 463 Monroe Drive		10f. ZIP CODE: 22443	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: 1941-1945	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Executive Secretary	16b. KIND OF BUSINESS/INDUSTRY: Republican National Committee	
17. FATHER'S NAME (First, Middle, Last): Harry E. Chapman, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Hazel E. Ale	
19a. INFORMANT'S NAME (Type/Print): Ralph Brensinger		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 463 Monroe Drive, Colonial Beach, Virginia 22443	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan Crematory DATE: 6/16	20c. LOCATION — City or Town, State: Alexandria, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Edward N. Brinsfield, Jr. M00052		22. NAME AND ADDRESS OF FACILITY: Brinsfield Funeral Home P.O. Box 279, Leonardtown, Maryland 20650	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Ventricular fibrillation	Hours
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Cardiac arrest	Minutes
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [X]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: C.W. Page MD	29c. LICENSE NUMBER: D 39605	29d. DATE SIGNED (Month, Day, Year): ▶ 6/19/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): C.W. Page, M.D. St. Mary's Hospital, Leonardtown, Maryland 20650		
31. DATE FILED (Month, Day, Year): JUN 16 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

Amend # 18, 6/30/95, DLB, St. Mary's Co. 95 20033

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WILLIAM Andrew COURCHEN			2. DATE OF DEATH (Month, Day, Year): JUNE 26 1995	3. TIME OF DEATH: 8.00 P. M
4. SOCIAL SECURITY NUMBER: 577-07-8370	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 84 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Mar 1, 1911	8. BIRTHPLACE (State or Foreign Country): South Carolina
9a. FACILITY NAME (If not institution, give street and number): St. Mary's Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Leonardtown		9c. COUNTY OF DEATH: St. Mary's
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: St. Mary's	10c. CITY, TOWN OR LOCATION: Mechanicsville		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 2505 Three Notch Road		10f. ZIP CODE: 20659		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Mechanic		16b. KIND OF BUSINESS/INDUSTRY: Car Dealer	
17. FATHER'S NAME (First, Middle, Last): Benjamin Courchen		18. MOTHER'S NAME (First, Middle, Maiden Surname): ~~Elizabeth~~ Sallie T. ~~Slickter~~ Smith		
19a. INFORMANT'S NAME (Type/Print): Betty L. Courchen		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2505 Three Notch Rd., Mechanicsville, MD 20659		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Richland Baptist Cem DATE: 7/1/95		20c. LOCATION — City or Town, State: Storck, Virginia
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Michael K. Gardiner		22. NAME AND ADDRESS OF FACILITY: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Congestive Heart Failure	mos.
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Renal Failure	Mos.
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year): —

28b. TIME OF INJURY: — M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED: —

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): —

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): —

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: 21425	29d. DATE SIGNED (Month, Day, Year): 6-28-95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): William D. Boyd, M.D. Leonardtown, Maryland 20650		
31. DATE FILED (Month, Day, Year): JUN 29 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

95 20034

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Russell Junior Deatrich
2. DATE OF DEATH (Month, Day, Year): 6 25 95
3. TIME OF DEATH: 320 A M
4. SOCIAL SECURITY NUMBER: 220-16-4049
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 72 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Sept. 13, 1922
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Washington County Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown
9c. COUNTY OF DEATH: Washington

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Washington
10c. CITY, TOWN OR LOCATION: Hagerstown
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 12026 Mayfair Ave.
10f. ZIP CODE: 21742
10g. CITIZEN OF WHAT COUNTRY?: U.S.A
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WW II
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Equipment Operator
16b. KIND OF BUSINESS/INDUSTRY: Construction Co.
17. FATHER'S NAME (First, Middle, Last): Russell Ferry Deatrich
16. MOTHER'S NAME (First, Middle, Maiden Surname): Blanche Katherine Ausherman
19a. INFORMANT'S NAME (Type/Print): Helen V. Deatrich
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12026 Mayfair Ave. Hagerstown, Md. 21742
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Lawn Memorial Pk. — DATE: 6-28-95
20c. LOCATION — City or Town, State: Hagerstown, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dennis L. Davis
22. NAME AND ADDRESS OF FACILITY: Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. ACUTE RESPIRATORY FAILURE — Hours
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. LEFT LUNG CANCER — Days
DUE TO (OR AS A CONSEQUENCE OF):
c. METASTATIC LUNG CANCER — Months
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.
ACUTE DIVERTICULITIS WITH RUPTURE CAUSING PNEUMOPERITONEUM

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [X] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] FAMILY PHYSICIAN — FOR A. DITTO, MD
29c. LICENSE NUMBER: D7067
29d. DATE SIGNED (Month, Day, Year): 6/26/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): STEPHEN E. METZNER, MD 740 NORTHERN AVE. HAGERSTOWN, MD
31. DATE FILED (Month, Day, Year): JUN 26 1995
32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

95 20035

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Eunice Jean DEAN			2. DATE OF DEATH (Month, Day, Year): June 23 1995	3. TIME OF DEATH: 1500 P M
4. SOCIAL SECURITY NUMBER: 230-32-1467	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 65 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): Jan. 21, 1930	8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): Washington County Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown		9c. COUNTY OF DEATH: Washington

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Williamsport	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 10518 Honeyfield Rd.		10f. ZIP CODE: 21795	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Accountant	16b. KIND OF BUSINESS/INDUSTRY: County Commuter	
17. FATHER'S NAME (First, Middle, Last): Hobert Mervie Reedy		18. MOTHER'S NAME (First, Middle, Maiden Surname): Dora Smith	
19a. INFORMANT'S NAME (Type/Print): James D. Dean		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10518 Honeyfield Rd. Williamsport, MD. 21795	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place): Dean Family Cemetery DATE: June 26, 1995	20c. LOCATION — City or Town, State: Swift Run Gap, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: Osborne Funeral Home	P.O.Box 348 Williamsport, MD. 21795	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute respiratory failure with respiratory acidosis	12 hrs
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF): Severe Obstructive pulmonary disease	years
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Arterial occlusion of left lower extremity, recent onset atrial fibrillation

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY ___ M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
			28d. DESCRIBE HOW INJURY OCCURED

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Charles C. Spencer MD	29c. LICENSE NUMBER: D111133	29d. DATE SIGNED (Month, Day, Year): June 23, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 1198 Kenly Ave Hagerstown MD Charles C. Spencer		
31. DATE FILED (Month, Day, Year): JUN 26 1995	32. REGISTRAR'S SIGNATURE: [signature]	

OHMH-16 Rev 1/89

95 20036

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Harry Pershing DAY				2. DATE OF DEATH (Month, Day, Year): June 25, 1995	3. TIME OF DEATH: 3:10 PM
4. SOCIAL SECURITY NUMBER: 215-26-2082	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Nov. 16, 1918
8. BIRTHPLACE (State or Foreign Country): Maryland					
9a. FACILITY NAME (If not institution, give street and number): 24 Bittersweet Drive	9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown	9c. COUNTY OF DEATH: Washington			

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Hagerstown	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 24 Bittersweet Drive	10f. ZIP CODE: 21742	10g. CITIZEN OF WHAT COUNTRY?: USA	

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: W. W. II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): 5+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Director of Check distribution	16b. KIND OF BUSINESS/INDUSTRY: credit card company	
17. FATHER'S NAME (First, Middle, Last): George Harrison Day	18. MOTHER'S NAME (First, Middle, Maiden Surname): Bessie Lee Lynch		
19a. INFORMANT'S NAME (Type/Print): Margaret Day	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 24 Bittersweet Dr., Hagerstown, Md. 21740		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Rocky Gap Vet. Cemetery	DATE: 6-29-95	20c. LOCATION — City or Town, State: Flintstone, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Scott Minnich	22. NAME AND ADDRESS OF FACILITY: MINNICH FUNERAL HOME 415 E.Wilson Blvd.,Hagerstown,Md. 21740		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardiorespiratory Failure	Few Days
DUE TO (OR AS A CONSEQUENCE OF): b.	Carcinoma of Stomach.	3-4 Mos.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	Renal Failure	1-2 Mos
DUE TO (OR AS A CONSEQUENCE OF): d.	Hypertension.	Sev. Years.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: T A Pasha MD	29c. LICENSE NUMBER: D35497	29d. DATE SIGNED (Month, Day, Year): 6/27/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): T.A. PASHA MD 376 MICE ST. HAGERSTOWN MD 21740		
31. DATE FILED (Month, Day, Year): JUN 20 1995	32. REGISTRAR'S SIGNATURE: Julia Dudley Reed	

DHMH-16 Rev 1/99

Amended #8, 6/14/95, PAK, Allegany County

95 20037

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BETTY JANE DURBIN

2. DATE OF DEATH Month: JUNE Day: 11 Year: 1995

3. TIME OF DEATH: 7:35 A M

4. SOCIAL SECURITY NUMBER: 220-16-6701

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 69 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): Apr. 17, 1926

8. BIRTHPLACE (State or Foreign Country): MARYLAND

9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL

9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND

9c. COUNTY OF DEATH: ALLEGANY

RESIDENCE OF DECEDENT

10a. STATE: WEST VA

10b. COUNTY: MINERAL

10c. CITY, TOWN OR LOCATION: RIDGELEY

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 20 PERRY STREET

10f. ZIP CODE: 26753

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 9
College (1-4 or 5 +):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): TRAINING DIRECTOR

16b. KIND OF BUSINESS/INDUSTRY: SEARS - RETAIL STORE

17. FATHER'S NAME (First, Middle, Last): JAMES PAUL DITTMER

18. MOTHER'S NAME (First, Middle, Maiden Surname): VILLA GRACE ROOT

19a. INFORMANT'S NAME (Type/Print): LINDA DEREMER

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 114 PARK STREET - CUMBERLAND, MD 21502

20a. METHOD OF DISPOSITION 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): MT. TABOR CEMETERY DATE: 6/13/95

20c. LOCATION — City or Town, State: SPRING GAP, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Wendy N. Upchurch

22. NAME AND ADDRESS OF FACILITY: GEORGE-UPCHURCH FUNERAL HOME, P.A.
202 GREENE ST., CUMBERLAND, MD 21502

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Acute MI	15 days
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. DUE TO (OR AS A CONSEQUENCE OF):	Multiorgan failure	12 days
c. DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☑

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: N. McCulley MD

29c. LICENSE NUMBER: D 44712

29d. DATE SIGNED (Month, Day, Year): ▶ JUNE 13 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): N. McCulley 902 Kent Drive Cumberland, Md 21502

31. DATE FILED (Month, Day, Year): JUN 14 1995

32. REGISTRAR'S SIGNATURE: Marlene Randall

DHMH-16 Rev 1/89

95 20038

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

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TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Margaret de la Croix			2. DATE OF DEATH (Month, Day, Year): June 21, 1995	3. TIME OF DEATH: 5:30 A M
4. SOCIAL SECURITY NUMBER: 217-44-0272	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 91 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Sept. 5, 1903	8. BIRTHPLACE (State or Foreign Country): Massachusetts
9a. FACILITY NAME (If not institution, give street and number): 7505 Ben Avon Road			9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda	9c. COUNTY OF DEATH: Montgomery
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Bethesda		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 7505 Ben Avon Road		10f. ZIP CODE: 20817		10g. CITIZEN OF WHAT COUNTRY? United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4 or 5+): 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Administrator		16b. KIND OF BUSINESS/INDUSTRY: United States Government
17. FATHER'S NAME (First, Middle, Last): William Sheehan			18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Maloney	
19a. INFORMANT'S NAME (Type/Print): Gene R. de la Croix		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5809 Nicholson Lane, N. Bethesda, Maryland 20852		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Gate of Heaven Cemetery DATE: June 24, 1995		20c. LOCATION — City or Town, State: Silver Spring, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michael E. Higgins M00846		22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Breast Cancer	1 Year
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation
Hyperparathyroidism

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
John L Lawson MD	DC17914	▶ June 21, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John L. Lawson, M.D., 1800 I Street, N.W., #602, Washington, D.C. 20006-5407

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 22 1995	Julia Davidson-Randall

DHMH-16 Rev 1/89

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95 20039

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Rakhil Dragina					2. DATE OF DEATH (Month, Day, Year): June 17 95	3. TIME OF DEATH: 1700 PM
4. SOCIAL SECURITY NUMBER: 216-39-7319	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 75 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): DEC 9 1919	8. BIRTHPLACE (State or Foreign Country): Russia
9a. FACILITY NAME (If not institution, give street and number): Shady Grove Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Rockville			9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Gaithersburg	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 10008 Trafalgar Square		10f. ZIP CODE: 20877	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: X	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Singer	16b. KIND OF BUSINESS/INDUSTRY: Opera
17. FATHER'S NAME (First, Middle, Last): Aron Goldberg		18. MOTHER'S NAME (First, Middle, Maiden Surname): Faina Usherovich	
19a. INFORMANT'S NAME (Type/Print): Yan Gamarnik		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10008 Trafalgar Square Gaithersburg MD 20877	

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place): Judean Memorial Gardens	DATE: 6-19	20c. LOCATION — City or Town, State: Olney MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Edward Sagel	22. NAME AND ADDRESS OF FACILITY: Edward Sagel Funeral Direction 1091 Rockville Pike Rockville MD 20852		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Colon Cancer	Six months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D33686	29d. DATE SIGNED (Month, Day, Year): ▶ June 18, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Kenneth Miller, MD 1111 Rockville Pike Ste. D. Olney, MD 20832

31. DATE FILED (Month, Day, Year): JUN 20 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DHMN-16 Rev 1/89

3

95 20040

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Joseph Edward Dyson			2. DATE OF DEATH (Month, Day, Year): June 15, 1995	3. TIME OF DEATH: 1545 M
4. SOCIAL SECURITY NUMBER: 219-46-9835	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 45 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): October 7, 1949	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): St. Marys City		9b. CITY, TOWN OR LOCATION OF DEATH: St. Mary's City	9c. COUNTY OF DEATH: St. Mary's	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: St. Mary's	10c. CITY, TOWN OR LOCATION: Lexington Park	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1307A Liberty Street		10f. ZIP CODE: 20653	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+): - - - -	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Custodian	16b. KIND OF BUSINESS/INDUSTRY: Contracting Services	
17. FATHER'S NAME (First, Middle, Last): John William Dyson		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Lilly Washington	
19a. INFORMANT'S NAME (Type/Print): Mary Herbert		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Star Route Box 4-A, Leonardtown, Maryland 20650	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Charles Memorial DATE: 6/21	20c. LOCATION — City or Town, State: Leonardtown, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Edward N. Brinsfield, Jr. M00052		22. NAME AND ADDRESS OF FACILITY: Brinsfield Funeral Home, P.O. Box 279, Leonardtown, Maryland 20650	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Fractured Skull	Sec
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Auto Accident	Sec
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. —

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) County Road

27. MANNER OF DEATH: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year): 6-15-95	28b. TIME OF INJURY: 1030 M	28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO	28d. DESCRIBE HOW INJURY OCCURED: Auto Accident
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): ST. MARY'S City - Road			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Above

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D24285	29d. DATE SIGNED (Month, Day, Year): ▶ 6-19-95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): William Boyd, M.D. 17 Jefferson Street, Leonardtown, Maryland 20650

31. DATE FILED (Month, Day, Year): JUN 20 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

95 20041

1 FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DONALD M. EMERICK			2. DATE OF DEATH (Month, Day, Year): June 17, 1995	3. TIME OF DEATH: 10:55 aM
4. SOCIAL SECURITY NUMBER: 213-24-6998	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 65 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Aug. 20, 1929	8. BIRTHPLACE (State or Foreign Country): Ellerslie, MD
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland		9c. COUNTY OF DEATH: Allegany

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Ellerslie	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 14017 Ellerslie Rd., P. O. Box 213		10f. ZIP CODE: 21529	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Repair person	16b. KIND OF BUSINESS/INDUSTRY: Utility: Natural Gas	
17. FATHER'S NAME (First, Middle, Last): William Howard Emerick		18. MOTHER'S NAME (First, Middle, Maiden Surname): Edythe Watts	
19a. INFORMANT'S NAME (Type/Print): Peggy Ann Emerick		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P. O. Box 213, Ellerslie, MD 21529	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Cooks Mills Cemetery DATE 6/20/95	20c. LOCATION — City or Town, State: RD, Hyndman, PA 15545	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Harvey H Zeigler		22. NAME AND ADDRESS OF FACILITY: Harvey H. Zeigler Funeral Home Hyndman, PA 15545-0636	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such es cerdiac or reepiratory arreat, ahock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Non-Small Cell Advanced Carcinoma of Lung	2 years
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [X] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D 23371	29d. DATE SIGNED (Month, Day, Year): ▶ June, 19, 95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Qamar Zaman-Johnson Heights Medical Building-Cumberland, MD 21502		
31. DATE FILED (Month, Day, Year): JUN 20 1995	32. REGISTRAR'S SIGNATURE	

10

DHMH-16 Rev 1/89

95 20042

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Lawrence Eig				2. DATE OF DEATH (Month, Day, Year): June 17 1995	3. TIME OF DEATH: 10:35P M
4. SOCIAL SECURITY NUMBER: 579-38-6442	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 68 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): July 14, 1926	8. BIRTHPLACE (State or Foreign Country): Wash. DC
9a. FACILITY NAME (If not institution, give street and number): Easton Memorial Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Easton		9c. COUNTY OF DEATH: Talbot

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Gaithersburg	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 9701 Fields Road		10f. ZIP CODE: 20878	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5 +): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Realtor	16b. KIND OF BUSINESS/INDUSTRY: Real Estate
17. FATHER'S NAME (First, Middle, Last): Sam Eig		18. MOTHER'S NAME (First, Middle, Maiden Surname): Esther Koenick	
19a. INFORMANT'S NAME (Type/Print): Jacqueline B. Eig (Wife)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9701 Fields Rd. Gaithersburg, Maryland 20878	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Judean DATE: 6/20	20c. LOCATION — City or Town, State: Olney, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert Hammer		22. NAME AND ADDRESS OF FACILITY: Danzansky-Goldberg Memorial Chapels, Inc 1170 Rockville Pike Rockville, Md. 20852	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Massive Hematoma, left external oblique abdominis	< 24 Hrs
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Hemorrhagic diasthesis DUE TO (OR AS A CONSEQUENCE OF):	Uncertain
	c. ? Trauma DUE TO (OR AS A CONSEQUENCE OF):	Uncertain
	d. Arteriosclerosis + chronic pyelonephritis	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Open fracture, rt. tibia
Hypertensive + arteriosclerotic heart disease

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [X]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Robert W. Trever, M.D.	29c. LICENSE NUMBER: D10938	29d. DATE SIGNED (Month, Day, Year): 6-18-95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Robert W. Trever-7696 Ocean Gateway-Easton, Maryland 21601		
31. DATE FILED (Month, Day, Year): JUN 20 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

20

Amended # 1, 6/20/95 MRT Montgomery County

95 20043

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

EDWARDS, LAURA

10

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LAURA J. EDWARDS			2. DATE OF DEATH (Month, Day, Year): JUNE 17, 1995	3. TIME OF DEATH: 3:22 A M
4. SOCIAL SECURITY NUMBER: 217-01-7262 ~~70-6262~~	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 85 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): JAN. 21, 1910	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): LAUREL REGIONAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: LAUREL		9c. COUNTY OF DEATH: PRINCE GEORGES

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: DERWOOD	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 7509 NEEDWOOD ROAD		10f. ZIP CODE: 20855	10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER	16b. KIND OF BUSINESS/INDUSTRY: OWN HOME	
17. FATHER'S NAME (First, Middle, Last): ELIJAH LEIZEAR		18. MOTHER'S NAME (First, Middle, Maiden Surname): BEULAH N. TAYLOR	
19a. INFORMANT'S NAME (Type/Print): NANCY CHAPMAN		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 108 RIDGE ROAD WASHINGTON GROVE, MARYLAND 20880	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): UNION CEMETERY DATE: 6/22/95	20c. LOCATION — City or Town, State: BURTONSVILLE, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Muriel H. Barber		22. NAME AND ADDRESS OF FACILITY: MURIEL H. BARBER FUNERAL HOME 20882 P.O. BOX 5038 LAYTONSVILLE, MARYLAND	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pneumonia	30 DAYS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Cerebrovascular Accident	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Corpora Pedunculata with Prior Bleeding
Rheumatoid Arthritis

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one):
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Dennis R. Schumer MD	29c. LICENSE NUMBER: D15666	29d. DATE SIGNED (Month, Day, Year): ▶ 6/17/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dennis R. Schumer MD - 14701 Connecticut Ave. #102 Laurel MD 20707		
31. DATE FILED (Month, Day, Year): JUN 19 1995	32. REGISTRAR'S SIGNATURE: Julie Davidson Parker	

DHMH-16 Rev 1/89

95-3651-510
ML

ITEMS: 23 PART I, II, 27, PER MEO FILM G-725 7/3/95 t.t

95 20044

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WILLIAM D. FORTNER					2. DATE OF DEATH (Month, Day, Year): JUNE 22 1995	3. TIME OF DEATH: 8:45 AM
4. SOCIAL SECURITY NUMBER: 211-28-2011	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 55 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Dec. 10, 1939	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): 1404 KUPER PLACE			9b. CITY, TOWN OR LOCATION OF DEATH: baltimore city		9c. COUNTY OF DEATH:	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore City	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1404 Kuper Place		10f. ZIP CODE: 21223	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9 / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Owner/Operator	16b. KIND OF BUSINESS/INDUSTRY: Service Station	
17. FATHER'S NAME (First, Middle, Last): Troy Fortner		18. MOTHER'S NAME (First, Middle, Maiden Surname): Beatrice J. Adams	
19a. INFORMANT'S NAME (Type/Print): Rickey W. Fortner	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 169 Hollingsworth Manor - Elkton, MD 21921		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): St. John's Methodist Cem. DATE: 6-24 1995	20c. LOCATION — City or Town, State: Lewisville, PA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Donald S. Hicks	22. NAME AND ADDRESS OF FACILITY: Hicks Home for Funerals, P.A. 103 West Stockton Street Elkton, MD 21921-5521		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. DILATED CARDIOMYOPATHY	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PNEUMONIA

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John Locke MD	29c. LICENSE NUMBER: O.C.M.E.	29d. DATE SIGNED (Month, Day, Year): ▶ JUNE 23,1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. LAWSON LOCKE, MD	111 Penn Street, Baltimore, Maryland 21201	
31. DATE FILED (Month, Day, Year): JUL 03 1995	32. REGISTRAR'S SIGNATURE: John Hudson Randall	

DHMH-18 Rev 1/89

95 20045

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Edith L. Fritter			2. DATE OF DEATH (Month, Day, Year): June 14 1995	3. TIME OF DEATH: 3:20 am. M
4. SOCIAL SECURITY NUMBER: 579-28-3713	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 70 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): March 21, 1925	8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): Globel Health Care Center		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH: Baltimore City
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Baltimore City	10c. CITY, TOWN OR LOCATION: Baltimore		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 807 Brunswick Rd.		10f. ZIP CODE: 21221		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Waitress	16b. KIND OF BUSINESS/INDUSTRY: Restaurants		
17. FATHER'S NAME (First, Middle, Last): Marion Clyde Fritter		18. MOTHER'S NAME (First, Middle, Maiden Surname): Hazel Olena Baker		
19a. INFORMANT'S NAME (Type/Print): Richard E. Fritter	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2545 Bicknell Rd., MArbury, Md. 20658			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Chicamuxen U.M.Ch. Cem. DATE: June 16, 1995	20c. LOCATION — City or Town, State: Chicamuxen, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] M00668	22. NAME AND ADDRESS OF FACILITY: Williams Funeral Home, P.A. Rt. 225 & Glymont Rd., Indian Head, Md			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CVA-Multiple
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Hypertension
DUE TO (OR AS A CONSEQUENCE OF):
c. CHF
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	D22409	▶ 6/21/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Joseph D'Antonio, Jr. M.D. 7401 Osler Dr. Balto, Md. 21204

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 23 1995	[signature]

DHMH-16 Rev 1/89

95 20046

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): NORMAN LEWIS FOLTZ			2. DATE OF DEATH: MONTH June 29, DAY 1995 YEAR	3. TIME OF DEATH: BETWEEN MID NIGHT + 7 AM M
4. SOCIAL SECURITY NUMBER: 214-09-1850	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 78 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Feb. 4, 1917
8. BIRTHPLACE (State or Foreign Country): Maryland				
9a. FACILITY NAME (If not institution, give street and number): 18032 Par Three Drive		9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown		9c. COUNTY OF DEATH: Washington

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Hagerstown	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 18032 Par Three Drive		10f. ZIP CODE: 21740	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years; College (1-4 or 8+):	16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Executive Director	16b. KIND OF BUSINESS/INDUSTRY: Housing Authority	
17. FATHER'S NAME (First, Middle, Last): Samuel Elmer Foltz		18. MOTNER'S NAME (First, Middle, Maiden Surname): Clarissa Morin	
19a. INFORMANT'S NAME (Type/Print): Kathleen Foltz		19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18032 Par Three Drive, Hagerstown, MD 21740	
20a. METNOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Rest Haven Cemetery	DATE: July 3, 1995	20c. LOCATION — City or Town, State: Hagerstown, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶Douglas A. Fiery Douglas A. Fiery		22. NAME AND ADDRESS OF FACILITY: Douglas A. Fiery Funeral Home 21742-3489 1331 Eastern Blvd. North, Hagerstown, MD	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardio Pulmonary Arrest DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF):	
	c. Atherosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD	29c. LICENSE NUMBER: D-12444	29d. DATE SIGNED (Month, Day, Year): ▶ 6-29-1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		
31. DATE FILED (Month, Day, Year): JUN 29 1995	32. REGISTRAR'S SIGNATURE	

OHMH-16 Rev 1/89

95 20047

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): FRANCES ANNA FRITZ			2. DATE OF DEATH (Month, Day, Year): JUNE 22 1995	3. TIME OF DEATH: 7:50 P.M. M
4. SOCIAL SECURITY NUMBER: 217-10-4687	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 80 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Oct. 3,1914	8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND		9c. COUNTY OF DEATH: ALLEGANY
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Frostburg		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 320 Allegany St.		10f. ZIP CODE: 21532		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Receptionist		16b. KIND OF BUSINESS/INDUSTRY: Banking
17. FATHER'S NAME (First, Middle, Last): Alfred Hunter		18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Kelso		
19a. INFORMANT'S NAME (Type/Print): Alfred W. Fritz		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 320 Allegany St. Frostburg, Md. 21532		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Frostburg Memorial Park DATE: Jun26,95		20c. LOCATION — City or Town, State: Frostburg, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert C. Adams		22. NAME AND ADDRESS OF FACILITY: Merritt-Adams Funeral Home 404 Decatur St. Cumberland, Md. 21502		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complicetione that ceused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heert feilure. List only one ceuse on eech line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Respiratory distress Syndrome	8 days
Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in deeth) LAST	DUE TO (OR AS A CONSEQUENCE OF): b. Left lower lobe pneumonia	10 days
	DUE TO (OR AS A CONSEQUENCE OF): c.	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal insufficiency
Liver dysfunction

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	29a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	29f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD FACP	29c. LICENSE NUMBER: D13601	29d. DATE SIGNED (Month, Day, Year): ▶ JUNE 22 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): V.R. FELIPA M.D. 925 BISHOP WALSH ROAD CUMBERLAND, MD. 21502

31. DATE FILED (Month, Day, Year): JUN 23 1995	32. REGISTRAR'S SIGNATURE: [signature] Director Randall

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OHMH-16 Rev 1/89

95 20048

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month / Day / Year)	3. TIME OF DEATH
THOMAS	JOSEPH	FARRELL Sr.	JUNE 18, 1995	10:25 AM

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
214-34-1337	1 X M 2 ☐ F	58 YRS.			Jan. 16, 1937	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Sacred Heart Hospital	Cumberland	Allegany

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Allegany	Mt. Savage	1 X YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
13222 Yellow Row	21545	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 X YES 2 ☐ NO IF YES, GIVE WAR OR DATES: Korean Conflict	1 ☐ YES 2 X NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12	0	Brick Layer	Self Employed

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Thomas F. Farrell	Cora Geary

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Kathleen Farrell	13222 Yellow Row Mt. Savage, Maryland 21545

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Fbg. Memorial Park	June 20,95	Frostburg, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ John R. Durst	Durst Funeral Home 57 Frost Avenue Frostburg, Maryland 21532

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Respiratory Failure	30 minutes
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Cardiac Dysrhythmia	45 minutes
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Acute Myocardial Infarction	1 hour
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Subdural Hematoma Hypertension
Diabetis Mellitus Arteriosclerosis

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 X NO	1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN X

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 X NO	HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	D012414	▶ JUNE 19 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DR. JESUS TAN, M.D., FROSTBURG PLAZA, FROSTBURG, MD 21532

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 19 1995	[signature]

DHMH-16 Rev 1/89

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95 20049

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARTHA BLAKE FORDYCE			2. DATE OF DEATH (Month, Day, Year): JUNE 10 1995	3. TIME OF DEATH: 2103 M
4. SOCIAL SECURITY NUMBER: 236-56-2098	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 82 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Nov 23, 1912	8. BIRTHPLACE (State or Foreign Country): WV
9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND		9c. COUNTY OF DEATH: ALLEGANY

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: LaVale	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 766 National Highway		10f. ZIP CODE: 21502	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): homemaker	16b. KIND OF BUSINESS/INDUSTRY: own home	
17. FATHER'S NAME (First, Middle, Last): Morris G. Henderson		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ninnie Clovis	
19a. INFORMANT'S NAME (Type/Print): Richard Fordyce		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 766 National Highway; LaVale, MD 21502	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Wadestown Cemetery	DATE: 06/14	20c. LOCATION — City or Town, State: Wadestown, WV
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James F Scarpelli		22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home for Owen Funeral Home, Cumberland, MD 21502	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Cardiac arrest	15 min
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Cardiac Arrythmia	2 wk
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Coronary Atherosclerosis	10 yr +
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Ischemic bowel with Intestinal Obstruction
Prior Carcinoma of Colon Pichi's Disease

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: ☒ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: ☒ 1 Natural; 2 ☐ Accident; 3 ☐ Suicide; 4 ☐ Homicide; 5 ☐ Pending Investigation; 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): ☒ 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: V. Mazzocco MD

29c. LICENSE NUMBER: D 07135

29d. DATE SIGNED (Month, Day, Year): JUNE 10, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MAZZOCCO, V. EUGENE, M.D. BMG, 912 SETON DRIVE CUMBERLAND, MD. 21502

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31. DATE FILED (Month, Day, Year): JUN 13 1995

32. REGISTRAR'S SIGNATURE: Theodosia Randall

OHMH-18 Rev 1/89

95 20050

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Jeanette Frank

2. DATE OF DEATH (Month, Day, Year): June 21, 1995

3. TIME OF DEATH: 4:10 A M

4. SOCIAL SECURITY NUMBER: 086-09-9288

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 77 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): August 31, 1917

8. BIRTHPLACE (State or Foreign Country): New York

9a. FACILITY NAME (If not institution, give street and number): Suburban Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda

9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Md.

10b. COUNTY: Montgomerey

10c. CITY, TOWN OR LOCATION: Rockville

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 5901 Montrose Rd. Apt. C402

10f. ZIP CODE: 20852

10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk

16b. KIND OF BUSINESS/INDUSTRY: Private

17. FATHER'S NAME (First, Middle, Last): Isaac Frank

18. MOTHER'S NAME (First, Middle, Maiden Surname): Tillie Jackson

19a. INFORMANT'S NAME (Type/Print): Henrietta Selss

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5901 Montrose Rd. Apt. N600 Rockville, Md. 20852

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Menorah Gardens DATE: 6/22/95

20c. LOCATION — City or Town, State: Rockville, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]

22. NAME AND ADDRESS OF FACILITY: Edward Sagel Funeral Direction 1091 Rockville Pike Rockville, Md. 20852

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Congestive heart failure	Months
DUE TO (OR AS A CONSEQUENCE OF):	b. Coronary heart disease	years
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted eventa resulting in death) LAST	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.: Chronic obstructive pulmonary disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature], M.D., Attending Physician

29c. LICENSE NUMBER: D 61193

29d. DATE SIGNED (Month, Day, Year): ▶ 6-21-95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Sidney S. Cohen, MD 12 Congressional Lane, Rockville, MD 20852

31. DATE FILED (Month, Day, Year): JUN 23 1995

32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/99

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6

95 20051

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Margery C. Flanagan

2. DATE OF DEATH (Month, Day, Year): June 19, 1995

3. TIME OF DEATH: 11:50 P M

4. SOCIAL SECURITY NUMBER: 057 22 9753

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 67 YRS.

IF UNDER 1 YEAR — MONTHS / DAYS; IF UNDER 24 HRS. — HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): April 7, 1928

8. BIRTHPLACE (State or Foreign Country): Connecticut

9a. FACILITY NAME (If not institution, give street and number): Suburban Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda

9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Montgomery

10c. CITY, TOWN OR LOCATION: Chevy Chase

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER: 5081 Bradley Blvd

10f. ZIP CODE: 20815

10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4 or 5+): -

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk

16b. KIND OF BUSINESS/INDUSTRY: Marketing Company

17. FATHER'S NAME (First, Middle, Last): Thomas J. Flanagan

18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine Myler

19a. INFORMANT'S NAME (Type/Print): Mary M. Fitzpatrick

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4991 Battery Lane, Bethesda, Maryland 20814

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Gate of Heaven Cemetery — DATE: June 23,1995

20c. LOCATION — City or Town, State: Silver Spring,Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] M00689

22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, MD 20814-3501

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or reapiratory erreat, shock, or heert feilure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition resulting in death) →	a. ANOXIC ENCEPHALOPATHY	1 WEEK
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentielly list conditions, if any, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ASCITES	MONTHS
DUE TO (OR AS A CONSEQUENCE OF):		
	c. CIRRHOSIS OF LIVER	MONTHS
DUE TO (OR AS A CONSEQUENCE OF):		
	d. ALCOHOL ABUSE	YEARS

PART ii. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i.

BENIGN OVARIAN MASS

ANEMIA

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☑

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one)

HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)

1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: P. Talwar, M.D.

29c. LICENSE NUMBER: D 36552

29d. DATE SIGNED (Month, Day, Year): ▶ JUNE 20 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): P. TALWAR, 50 WEDMONSTON DR. #401 ROCKVILLE MD. 20852

31. DATE FILED (Month, Day, Year): JUN 21 1995

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

10

95 20052

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): John Edward Flexer			2. DATE OF DEATH (Month, Day, Year): June 8, 1995	3. TIME OF DEATH: 2115 M
4. SOCIAL SECURITY NUMBER: 210-16-2104	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 68 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): August 30, 1926
8. BIRTHPLACE (State or Foreign Country): Pennsylvania				
9a. FACILITY NAME (If not institution, give street and number): St. Mary's Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Leonardtown	9c. COUNTY OF DEATH: St. Mary's		
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: St. Mary's	10c. CITY, TOWN OR LOCATION: Mechanicsville	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO	
10e. STREET AND NUMBER: 25 Beach Court	10f. ZIP CODE: 20659	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.		
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO; IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 6	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): School Teacher	16b. KIND OF BUSINESS/INDUSTRY: Public Schools	
17. FATHER'S NAME (First, Middle, Last): Ralph Flexer		18. MOTHER'S NAME (First, Middle, Maiden Surname): Marion Wolf		
19a. INFORMANT'S NAME (Type/Print): Delores J. Flexer		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 25 Beach Court, Mechanicsville, MD 20659		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Conyngham Union Cemetery	DATE	20c. LOCATION — City or Town, State: Conyngham, Pennsylvania	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Michael K. Blankenship, M00857		22. NAME AND ADDRESS OF FACILITY: Brinsfield Funeral Home, P.A. 59 N. Washington St., Leonardtown, MD 20650-0279		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. PROBABLE MYOCARDIAL INFARCTION	Sec
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ASCVD	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. HYPERTENSION	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) BOAT

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED: N/A
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: William Boyd MD	29c. LICENSE NUMBER: D14285	29d. DATE SIGNED (Month, Day, Year): ▶ 6-9-95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): William D. Boyd II, M.D., 17 Jefferson Street, Leonardtown, Maryland 20650		
31. DATE FILED (Month, Day, Year): JUN 13 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

95 20053

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EDWARD W. FRAKER			2. DATE OF DEATH (Month, Day, Year): JUNE 02 1995	3. TIME OF DEATH: 10:35 AM
4. SOCIAL SECURITY NUMBER: 513-10-2017	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 79 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): Mar. 26, 1916	8. BIRTHPLACE (State or Foreign Country): Kansas
9a. FACILITY NAME (If not institution, give street and number): Charlotte Hall Veterans Home		9b. CITY, TOWN OR LOCATION OF DEATH: Charlotte Hall		9c. COUNTY OF DEATH: St. Mary's

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Rockville	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1 Rollins Court		10f. ZIP CODE: 20852	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4 or 5+): 1 year	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Special Weapons Expert	16b. KIND OF BUSINESS/INDUSTRY: U.S. Navy	
17. FATHER'S NAME (First, Middle, Last): Walter Allen Fraker	18. MOTHER'S NAME (First, Middle, Maiden Surname): Cora [illegible] Satchel		
19a. INFORMANT'S NAME (Type/Print): Charity May Fraker	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1 Rollins Ct., Rockville, Maryland 20852		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan Crematory DATE: June 5, 1995	20c. LOCATION — City or Town, State: Alexandria, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Michael K Gardiner	22. NAME AND ADDRESS OF FACILITY: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. MULTIPLE ASPIRATION PNEUMONIAS	3 months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PARKINSONISM
DEPRESSION

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D38991	29d. DATE SIGNED (Month, Day, Year): June 2, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MICHAEL DIPPE 120 HOSPITAL ROAD PRINCE FREDERICK MD 20678		
31. DATE FILED (Month, Day, Year): JUN -6 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

95 20054

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CLAYTON CECIL GILLUM			2. DATE OF DEATH: MONTH JUNE DAY 18 YEAR 1995	3. TIME OF DEATH: 5:30 PM M
4. SOCIAL SECURITY NUMBER: 214-05-9740	5. SEX: XX 1 M 2 ☐ F	6. AGE (In yrs. last birthday): 88 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): JAN 7 1907
8. BIRTHPLACE (State or Foreign Country): MARYLAND				

9a. FACILITY NAME (If not institution, give street and number): 12527 McMULLEN HIGHWAY S.W.	9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND	9c. COUNTY OF DEATH: ALLEGANY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: ALLEGANY	10c. CITY, TOWN OR LOCATION: CUMBERLAND	10d. INSIDE CITY LIMITS? XX 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 12527 McMULLEN HIGHWAY S.W.		10f. ZIP CODE: 21502	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): U.S.POSTAL SERVICE	16b. KIND OF BUSINESS/INDUSTRY: MAIL CARRIER	
17. FATHER'S NAME (First, Middle, Last): HARRY C. GILLUM		18. MOTHER'S NAME (First, Middle, Maiden Surname): MYRTLE HENDRICKSON	
19a. INFORMANT'S NAME (Type/Print): BLANCHE A. GILLUM		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12527 McMULLEN HIGHWAY S.W. CUMBERLAND MARYLAND	
20a. METHOD OF DISPOSITION: XX 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): ZION MEMORIAL PARK JUNE 21	DATE: 1995	20c. LOCATION — City or Town, State: CUMBERLAND MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Dale L. Merritt		22. NAME AND ADDRESS OF FACILITY: MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Adenocarcinoma of Colon	7 months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO XX

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 XX NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES XX NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home XX 5 Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: XX 1 Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
XX 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Thomas E. Chappell MD	29c. LICENSE NUMBER: MD 35135	29d. DATE SIGNED (Month, Day, Year) ▶ 6/19/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type, Print): DR. THOMAS E. CHAPPELL 912 SETON DRIVE CUMBERLAND MARYLAND

31. DATE FILED (Month, Day, Year): JUN 19 1995	32. REGISTRAR'S SIGNATURE: Julie Marchesi-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6

95 20055

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HAZEL ELVA GILKEY		2. DATE OF DEATH (Month, Day, Year): JUNE 13, 1995	3. TIME OF DEATH: 1:35 P M
4. SOCIAL SECURITY NUMBER: 214-07-0945	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 87 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): April 23 1908
8. BIRTHPLACE (State or Foreign Country): PENNSYLVANIA			
9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND	9c. COUNTY OF DEATH: ALLEGANY	

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: ALLEGANY	10c. CITY, TOWN OR LOCATION: FROSTBURG	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: RD 1 LOARTOWN ROAD		10f. ZIP CODE: 21532	10g. CITIZEN OF WHAT COUNTRY?: U S A

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): UNKNOWN; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): OWNER/OPERATOR	16b. KIND OF BUSINESS/INDUSTRY: GROCERY STORE	
17. FATHER'S NAME (First, Middle, Last): MILTON I. BENNETT	18. MOTHER'S NAME (First, Middle, Maiden Surname): NORA STECKMAN		
19a. INFORMANT'S NAME (Type/Print): MARVIN BENNETT	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 720 ECHO VALE DRIVE BEDFORD, PA 15522		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): BEDFORD COUNTY MEM PK DATE 6/16	20c. LOCATION — City or Town, State: BEDFORD, PA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Douglas A Hafer	22. NAME AND ADDRESS OF FACILITY: HAFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY LAVALE, MD 21502		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	CARDIAC ARRHYTHMIA	4 MIN
DUE TO (OR AS A CONSEQUENCE OF): b.	DILATED CARDIOMYOPATHY	2 YEAR
DUE TO (OR AS A CONSEQUENCE OF): c.	CORONARY ARTERY DISEASE	10 YEARS
DUE TO (OR AS A CONSEQUENCE OF): d.		

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: INTRACTABLE CONGESTIVE HEART FAILURE

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Robert Welik	29c. LICENSE NUMBER: D31875	29d. DATE SIGNED (Month, Day, Year): ▶ JUNE 13/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Robert Welik, M.D. 902 Seton Drive Cumberland, MD 21502

31. DATE FILED (Month, Day, Year): JUN 16 1995	32. REGISTRAR'S SIGNATURE: Theodora Randall

DNMN-18 Rev 1/89

95 20056

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mary Ann Gloyd		2. DATE OF DEATH (Month, Day, Year): June 21, 1995	3. TIME OF DEATH: 2:08 A. M
4. SOCIAL SECURITY NUMBER: 579-10-3010	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 80 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): April 22, 1915
8. BIRTHPLACE (State or Foreign Country): Virginia			
9a. FACILITY NAME (If not institution, give street and number): 11804 Longdraft Court	9b. CITY, TOWN OR LOCATION OF DEATH: Gaithersburg	9c. COUNTY OF DEATH: Montgomery	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Gaithersburg	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 11804 Longdraft Court	10f. ZIP CODE: 20878	10g. CITIZEN OF WHAT COUNTRY?: United States	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4 or 5+): 1	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Librarian	16b. KIND OF BUSINESS/INDUSTRY: Gaithersburg Library	
17. FATHER'S NAME (First, Middle, Last): Earl Lester Myers	18. MOTHER'S NAME (First, Middle, Maiden Surname): Georga McFarland Ruebush		
19a. INFORMANT'S NAME (Type/Print): Gary M. Gloyd	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11630 Game Preserve Road, Gaithersburg, MD. 20878		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place): St. Rose of Lima Cemetery	DATE: 6/23	20c. LOCATION — City or Town, State: Gaithersburg, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Michael D. Gilbraus	22. NAME AND ADDRESS OF FACILITY: DeVol Funeral Home, 10 E.Deer Park Dr., Gaithersburg, MD. 20877		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. AGNOGENIC MYELOID METAPLASIA	6 YRS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: HYPERTENSION

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: James A. Brown MD	29c. LICENSE NUMBER: D07285	29d. DATE SIGNED (Month, Day, Year): June 21, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James A. Brown, M.D., 9707 Medical Center Drive, # 300, Rockville, MD. 20850

31. DATE FILED (Month, Day, Year): JUN 23 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMN-16 Rev 1/89

6

95 20057

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BENJAMIN F. GARTRELL, SR.					2. DATE OF DEATH (Month, Day, Year): JUNE 16, 1995	3. TIME OF DEATH: 11:20 A M
4. SOCIAL SECURITY NUMBER: 214-32-8599	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 60 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): MAY 15, 1935	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): MED BRIDGE NURSING HOME			9b. CITY, TOWN OR LOCATION OF DEATH: WHEATON		9c. COUNTY OF DEATH: MONTGOMERY	
RESIDENCE OF DECEDENT						
10a. STATE: MARYLAND	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: SILVER SPRING			10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO	
10e. STREET AND NUMBER: 1311 HORNELL DRIVE		10f. ZIP CODE: 20905			10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: 1957	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): OWNER - OPERATOR			16b. KIND OF BUSINESS/INDUSTRY: PLUMBING AND HEATING	
17. FATHER'S NAME (First, Middle, Last): ARCHIE GARTRELL SR.					18. MOTHER'S NAME (First, Middle, Maiden Surname): LAURA ELOISE ALLISON	
19a. INFORMANT'S NAME (Type/Print): ESTHER LOUISE GARTRELL		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1311 HORNELL DRIVE SILVER SPRING, MD. 20905				
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place): LAYTONSVILLE CEMETERY DATE: 6/20/95			20c. LOCATION — City or Town, State: LAYTONSVILLE, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Muriel H. Barber		22. NAME AND ADDRESS OF FACILITY: MURIEL H. BARBER FUNERAL HOME 20882 P.O.BOX 5038 LAYTONSVILLE, MARYLAND				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Lung Cancer	6 mo.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease
Chronic obstructive pulmonary disease

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [X] NO [ ] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
John Barr, MD	D21611	▶ JUNE 16, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John Barr, MD 10810 Connecticut Ave, Kensington, Md

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 19 1995	Julia Davidson Randall

DHMH-16 Rev 1/89

20+1

95 20058

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Dorothy Gerber				2. DATE OF DEATH (Month, Day, Year): June 14 1995	3. TIME OF DEATH: 12:29 A M
4. SOCIAL SECURITY NUMBER: 212.68.2430	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 87 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): MARCH 3,1908	8. BIRTHPLACE (State or Foreign Country): MASSACHUSETTS
9a. FACILITY NAME (If not institution, give street and number): Potomac Valley Nursing Home			9b. CITY, TOWN OR LOCATION OF DEATH: Rockville		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Chevy Chase	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 7412 Wyndale Lane		10f. ZIP CODE: 20815	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): +2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home

17. FATHER'S NAME (First, Middle, Last): Patrick Beehan	18. MOTHER'S NAME (First, Middle, Maiden Surname): Ann Connolly
19a. INFORMANT'S NAME (Type/Print): Willard Vick	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12313 Clemens Lane Silver Spring, Md. 20902

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Arlington National Cemetery	DATE: 6/21	20c. LOCATION — City or Town, State: Arlington, Va.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Vernon Simmons

22. NAME AND ADDRESS OF FACILITY: Joseph Gawler's Sons, Inc. 5130 Wisconsin Avenue, N.W. Washington, D.C. 20016

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory Failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. CVA	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Atrial Fibrillation	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURED
			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Phyllis Brandchaft	29c. LICENSE NUMBER: D29685	29d. DATE SIGNED (Month, Day, Year): ▶JUNE 14, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Phyllis Brandchaft, M.D. 10810 Connecticut Avenue Kensington, MD 20895

31. DATE FILED (Month, Day, Year): JUN 20 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DHMH-16 Rev 1/89

15

95 20059

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Hollis Allen Griswell			2. DATE OF DEATH: Month June, Day 19, Year 1995	3. TIME OF DEATH: 11:30 PM
4. SOCIAL SECURITY NUMBER: 554-32-9249	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 85 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): Jan.14,1910	8. BIRTHPLACE (State or Foreign Country): Georgia
9a. FACILITY NAME (If not institution, give street and number): 11406 Sherrie Lane		9b. CITY, TOWN OR LOCATION OF DEATH: Wheaton		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Wheaton	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 11406 Sherrie Lane		10f. ZIP CODE: 20902	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: 1931-1961	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 2	18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Officer	16b. KIND OF BUSINESS/INDUSTRY: US Navy

17. FATHER'S NAME (First, Middle, Last): Henry Carlton Griswell	16. MOTHER'S NAME (First, Middle, Maiden Surname): Charity Ann Jordan
19a. INFORMANT'S NAME (Type/Print): Mary Anita Griswell	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11406 Sherrie Lane, Wheaton, MD 20902

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Arlington National Cemetery	DATE: 6/29/95	20c. LOCATION — City or Town, State: Arlington, VA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Mark L. Willett		22. NAME AND ADDRESS OF FACILITY: Francis J. Collins Funeral Home, Inc. 500 University Blvd.W Sil.Spr.MD 20901	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirstory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CARDIO RESPIRATORY FAILURE	MINS.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. METASTATIC PROSTATE CANCER	YEARS
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Suresh Ratnam M.D.	29c. LICENSE NUMBER: 43010 57037	29d. DATE SIGNED (Month, Day, Year): ▶ 6/20/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SURESH RATNAM, BETHESDA NAVAL HOSPITAL. BETHESDA MD 20889

31. DATE FILED (Month, Day, Year): JUN 22 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DHMH-16 Rev 1/89

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95 20060

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Julia B Hardy			2. DATE OF DEATH (Month, Day, Year): June 20 1995	3. TIME OF DEATH: 9:20A M
4. SOCIAL SECURITY NUMBER: 219 34 7682	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 84 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 12/26/'10	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Calvert Nursing Center		9b. CITY, TOWN OR LOCATION OF DEATH: Prince Frederick		9c. COUNTY OF DEATH: Calvert
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Calvert	10c. CITY, TOWN OR LOCATION: Prince Frederick		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1730 Harris Road		10f. ZIP CODE: 20678		10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker		16b. KIND OF BUSINESS/INDUSTRY: Domestic
17. FATHER'S NAME (First, Middle, Last): Peter Reeder			18. MOTHER'S NAME (First, Middle, Maiden Surname): Nellie Brooks	
19a. INFORMANT'S NAME (Type/Print): Lucille M. Reynolds		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1730 Harris Road, Prince Frederick, MD 20678		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): St Philip's Ch Cem DATE 6/23/95		20c. LOCATION — City or Town, State: Aquasco, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Lloyd M. Estep		22. NAME AND ADDRESS OF FACILITY: Adams Funeral Home, PA Aquasco Road, Aquasco, MD. 20608		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CONGESTIVE HEART FAILURE	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): b. Atherosclerotic Heart disease	
	DUE TO (OR AS A CONSEQUENCE OF): c.	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: HYPERTENSION

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M Mathur MD | 29c. LICENSE NUMBER: D-23345 | 29d. DATE SIGNED (Month, Day, Year): ▶ 6/21/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print):

31. DATE FILED (Month, Day, Year): JUN 23 1995 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

95 20061

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEOENT'S NAME (First, Middle, Last): CLINTON ALAN HOFFMAN		2. DATE OF DEATH (Month, Day, Year): JUNE 21, 1995	3. TIME OF OEATH: 7 PM
4. SOCIAL SECURITY NUMBER: 218-06-2023	5. SEX: 1 ☒ M 2 ☐ F	8. AGE (In yrs. last birthday): 12 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 10-22-1982
8. BIRTHPLACE (State or Foreign Country): Texas			
9a. FACILITY NAME (If not institution, give street and number): BEACH AT 109TH ST.	9b. CITY, TOWN OR LOCATION OF DEATH: OCEAN CITY	9c. COUNTY OF DEATH: WORCESTER	

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY: WASHINGTON	10c. CITY, TOWN OR LOCATION: HAGERSTOWN	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 20310 AYOUB LANE	10f. ZIP CODE: 21742	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 years; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Student	16b. KIND OF BUSINESS/INDUSTRY: Public School	
17. FATHER'S NAME (First, Middle, Last): John R. Hoffman	18. MOTHER'S NAME (First, Middle, Maiden Surname): Debbie J. Tovornik		
19a. INFORMANT'S NAME (Type/Print): John R. Hoffman	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 20310 Ayoub Lane Hagerstown, Maryland 21742		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Rest Haven Cemetery DATE: 6-24-1995	20c. LOCATION — City or Town, State: Hagerstown, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Douglas A. Fiery	22. NAME AND ADDRESS OF FACILITY: Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, Md.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ASPHYXIATION	FEW MINUTES
	OUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	OUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERREO TO MEOICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF OEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) BEACH		
27. MANNER OF OEATH: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. OATE OF INJURY (Month, Day, Year): 6-21-95	28b. TIME OF INJURY: 5 PM	28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO
	28d. DESCRIBE HOW INJURY OCCURED: SAND CAVE-IN		
	28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify): BEACH	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29e. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Dorothy C. Holzworth, M.D.	29c. LICENSE NUMBER: D06241	29d. DATE SIGNED (Month, Day, Year): 6-22-95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DOROTHY C. HOLZWORTH M.D. 263 SNOW ST. SNOW HILL, MD. 21863

31. DATE FILED (Month, Day, Year): JUN 23 1995	32. REGISTRAR'S SIGNATURE: Julia Hudson-Reid

DHMH-16 Rev 1/89

95 20062

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mary Joan Harrison			2. DATE OF DEATH (Month, Day, Year): June 15, 1995	3. TIME OF DEATH: 9:30 A M
4. SOCIAL SECURITY NUMBER: 220-16-6824	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 75 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): April 22, 1920
8. BIRTHPLACE (State or Foreign Country): Maryland				
9a. FACILITY NAME (If not institution, give street and number): 811 Braddock Rd.-Residence	9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland	9c. COUNTY OF DEATH: Allegany		
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Cumberland	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER: 811 Braddock Road	10f. ZIP CODE: 21502	10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12):	College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): School Teacher	16b. KIND OF BUSINESS/INDUSTRY: Education	
17. FATHER'S NAME (First, Middle, Last): CARL F. Schmutz		18. MOTHER'S NAME (First, Middle, Maiden Surname): Esther C. Cavanaugh		
19a. INFORMANT'S NAME (Type/Print): William Richard Harrison		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1144 Greenfield Ave. Pittsburgh, Pa. 15217		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Rocky Gap Vet. Cemetery DATE: 6-19-95	20c. LOCATION — City or Town, State: Cumberland, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ernest A. Riley, Jr.		22. NAME AND ADDRESS OF FACILITY: Leasure-Stein, Inc. 230 Baltimore Ave. Cumberland, Md. 21502		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cerebral vascular accident	12 yrs
DUE TO (OR AS A CONSEQUENCE OF): b.	HTN	12 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.		
d.		June 15, 1995

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO Released

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
N. McCullough MD	D44712	▶ 6/15/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): N. McCullough 902 Seton Drive Cumberland, Md 21502

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 23 1995	[illegible] Randall

DHMH-16 Rev 1/89

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95 20063

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): KATIE PEARL HOUSE			2. DATE OF DEATH (Month, Day, Year): JUNE 18, 1995	3. TIME OF DEATH: 6:17 PM
4. SOCIAL SECURITY NUMBER: 219-03-8008	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 93 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): Feb. 7, 1902	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Sacred Heart Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland		9c. COUNTY OF DEATH: Allegany

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Barton	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Box 90		10f. ZIP CODE: 21521	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Home	
17. FATHER'S NAME (First, Middle, Last): Amos Green		18. MOTHER'S NAME (First, Middle, Maiden Surname): Rebecca Poland	
19a. INFORMANT'S NAME (Type/Print): Wilma J. Miller	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Box 90, Barton, Md. 21521		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. View Cemetery	DATE: June 21, 1995	20c. LOCATION — City or Town, State: Moscow Mills, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]	22. NAME AND ADDRESS OF FACILITY: Eichhorn-McKenzie Funeral Home, Lonaconing, Md. 21539		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Bilateral Pneumonia — 10 days

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia · Dehydration · Diabetes mellitus · Septicemia

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☑ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D14464	29d. DATE SIGNED (Month, Day, Year): ▶ JUNE 19, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DR. SIKANDER SANDHIR, M.D., 48 TARN TERRACE, FROSTBURG, MD 21502

31. DATE FILED (Month, Day, Year): JUN 22 1995 — REGISTRAR'S SIGNATURE: [signature]

DHMH-18 Rev 1/89

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Amended #4, 6/21/95, NDS, Allegany Co.

95 20064

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Regina Clara Hahn		2. DATE OF DEATH (Month, Day, Year): June 16, 1995	3. TIME OF DEATH: 11:35 AM
4. SOCIAL SECURITY NUMBER: 219-18-3584 220-10-8708	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 75 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Jan. 21, 1920
8. BIRTHPLACE (State or Foreign Country): MD			
9a. FACILITY NAME (If not institution, give street and number): Egle Nursing Home, Inc.	9b. CITY, TOWN OR LOCATION OF DEATH: LONACONING	9c. COUNTY OF DEATH: ALLEGANY	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Cumberland	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 10 N. Liberty Street	10f. ZIP CODE: 21502	10g. CITIZEN OF WHAT COUNTRY?: USA	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Carl Minke	18. MOTHER'S NAME (First, Middle, Maiden Surname): Clara (Hamilton)		
19a. INFORMANT'S NAME (Type/Print): Barbara Barton	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14902 Grant Street; Cresaptown, MD 21502		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Davis Memorial Cemetery; DATE: 06/20	20c. LOCATION — City or Town, State: Cumberland, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James F Scarpelli	22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home Cumberland, MD 21502		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Myocardial Infarction	instant
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Arteriosclerosis, Generalized	8 years.
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Leslie Miles MD	29c. LICENSE NUMBER: D07004	29d. DATE SIGNED (Month, Day, Year): 6/19/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Leslie R. Miles, M.D., 10 St. Peters Place, Lonaconing, MD 21539

31. DATE FILED (Month, Day, Year): JUN 21 1995	32. REGISTRAR'S SIGNATURE: Jean Preston-Kimball

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DHMH-16 Rev 1/89

95 20065

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LESTER LEROY HOSSELRODE			2. DATE OF DEATH (Month, Day, Year): JUNE 18, 1995	3. TIME OF DEATH: 09:15 AM
4. SOCIAL SECURITY NUMBER: 705-12-4919	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 83 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Sept. 23, 1911	8. BIRTHPLACE (State or Foreign Country): PA
9a. FACILITY NAME (If not institution, give street and number): Sacred Heart Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland		9c. COUNTY OF DEATH: Allegany

RESIDENCE OF DECEDENT

10a. STATE: PA	10b. COUNTY: Bedford	10c. CITY, TOWN OR LOCATION: Hyndman	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: R. D. #1, Box 68		10f. ZIP CODE: 15545	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 4; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Blacksmith	16b. KIND OF BUSINESS/INDUSTRY: Railroad	
17. FATHER'S NAME (First, Middle, Last): Henry L. Hosselrode		18. MOTHER'S NAME (First, Middle, Maiden Surname): Sara Annie Witt	
19a. INFORMANT'S NAME (Type/Print): Vivian L. Webber, daughter		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): R. D. 1, Box 68, Hyndman, PA 15545	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, cremetory or other place): Porter Cemetery	DATE: June 21, 1995	20c. LOCATION — City or Town, State: RD, Hyndman, PA 15545
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Harvey H. Zeigler	22. NAME AND ADDRESS OF FACILITY: Harvey H. Zeigler Funeral Home, Hyndman, PA 15545-0636		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Renal failure or Long Dialysis	3 years
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. DUE TO (OR AS A CONSEQUENCE OF):	Diabetes Mellitus	25 years
c. DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Ca of the Colon & GI Bleeding
Enlarged prostate PCOA

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [✓]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [✓] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [✓] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Chang H. Oh MD	29c. LICENSE NUMBER: D24951	29d. DATE SIGNED (Month, Day, Year): JUNE 19, 95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CHANG H. OH. MD. 48 TACEN TERRACE, FROSTBURG, MD 21532		
31. DATE FILED (Month, Day, Year): JUN 20 1995	32. REGISTRAR'S SIGNATURE: Julie Davidson Randall	

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DHMH-18 Rev 1/89

95 20066

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JANIECE MARGARET HIXON		2. DATE OF DEATH (Month, Day, Year): JUNE 13 1995	3. TIME OF DEATH: 15:30 PM
4. SOCIAL SECURITY NUMBER: 527-05-3514	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 76 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): Oct 9, 1918
8. BIRTHPLACE (State or Foreign Country): IN			
9a. FACILITY NAME (If not institution, give street and number): MEMORIAL HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND	9c. COUNTY OF DEATH: ALLEGANY	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Cumberland	10d. INSIDE CITY LIMITS? ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 603 Haddon Avenue	10f. ZIP CODE: 21502	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Harry Hinkle	18. MOTHER'S NAME (First, Middle, Maiden Surname): Dena (Gossard)		
19a. INFORMANT'S NAME (Type/Print): Elmer T. Hixon	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 603 Haddon Avenue; Cumberland, MD 21502		
20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Sunset Memorial Park DATE: 06/15	20c. LOCATION — City or Town, State: Cumberland, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James F Scarpelli	22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home Cumberland, MD 21502		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Advanced Lymphoma, Mixed	Oct. 18,94
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	b. Pancytopenia	4-6 months
DUE TO (OR AS A CONSEQUENCE OF):		
	c.	
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: for MD	29c. LICENSE NUMBER: D 23371	29d. DATE SIGNED (Month, Day, Year): ▶JUNE 15, 95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. QAMAR ZAMAN, SUITE 102, 625 KENT AVE., CUMBERLAND, MD 21502

31. DATE (Month, Day, Year): JUN 15 1995	32. REGISTRAR'S SIGNATURE

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DHMH-18 Rev 1/89

95 20067

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Rosalie C. Heintzelman			2. DATE OF DEATH (Month, Day, Year): June 14, 1995	3. TIME OF DEATH: 8:30 A M
4. SOCIAL SECURITY NUMBER: 137-22-5646	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 66 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): June 21, 1928	8. BIRTHPLACE (State or Foreign Country): New Jersey
9a. FACILITY NAME (If not institution, give street and number): 6516 Lone Oak Court		9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda		9c. COUNTY OF DEATH: Montgomery
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Bethesda		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 6516 Lone Oak Court		10f. ZIP CODE: 20817		10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5 +): 5+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker		16b. KIND OF BUSINESS/INDUSTRY: Own Home
17. FATHER'S NAME (First, Middle, Last): J. Pennington Creamer		18. MOTHER'S NAME (First, Middle, Maiden Surname): Hazel F. Bray		
19a. INFORMANT'S NAME (Type/Print): H. Henry Heintzelman		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6516 Lone Oak Court Bethesda, Maryland 20817		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place): Norland Cemetery DATE: June 17, 1995	20c. LOCATION — City or Town, State: Chambersburg, Pennsylvania		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Barry Bryant M00335	22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Emphysema	6 Years
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Tobacco Smoking	50 Years
DUE TO (OR AS A CONSEQUENCE OF):		
	c. Radiation Pneumonitis	1 Month
DUE TO (OR AS A CONSEQUENCE OF):		
	d. adenocarcinoma of the lung	2 Years

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☒ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

28. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY M | 26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 26d. DESCRIBE HOW INJURY OCCURED

26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Alan R. Pollack	D33443	▶ June 14, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Alan R. Pollack M.D. 809 Veirs Mill Road Rockville, Maryland 20851

31. DATE FILED (Month, Day, Year)	REGISTRAR'S SIGNATURE
JUN 19 1995	Julia Stevenson-Randall

DHMH-16 Rev 1/89

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95 20068

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): VIRGINIA Anne HORN
2. DATE OF DEATH (Month, Day, Year): JUNE 26 1995
3. TIME OF DEATH: 02.45 A.M
4. SOCIAL SECURITY NUMBER: 140-26-3434
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 76 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): September 25,1918
8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): St. Mary's Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Leonardtown
9c. COUNTY OF DEATH: St. Mary's

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: St. Mary's
10c. CITY, TOWN OR LOCATION: Lexington Park
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1214 Hilton Drive
10f. ZIP CODE: 20653
10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: n/a
17. FATHER'S NAME (First, Middle, Last): Edward Herrmann
18. MOTHER'S NAME (First, Middle, Maiden Surname): Virginia Anne Andrews
19a. INFORMANT'S NAME (Type/Print): Helen Horn
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1214 Hilton Drive., Lexington Park, MD 20653
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Lady of Grace Cemetery — DATE: 7-1-95
20c. LOCATION — City or Town, State: Langhorne, Pennsylvania
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Edward N. Brinsfield, Jr., MO0052
22. NAME AND ADDRESS OF FACILITY: Brinsfield Funeral Home, P.A. 59 N. Washington St., Leonardtown, MD 20650-0279

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardiogenic Shock	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Acute Myocardial Infarction	3 HRS
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Anil K Shah MD
29c. LICENSE NUMBER: D40593
29d. DATE SIGNED (Month, Day, Year): ▶ 6-26-95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Anil K. Shah, M.D., Medical Arts Building, Leonardtown, Maryland 20650
31. DATE FILED (Month, Day, Year): JUN 29 1995
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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95 20069

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JENNIFER INEZ JOHNSON			2. DATE OF DEATH (Month, Day, Year): 6 21 95	3. TIME OF DEATH: 5:10A M
4. SOCIAL SECURITY NUMBER: 161-40-1284	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 45 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 8-19-49	8. BIRTHPLACE (State or Foreign Country): WAYNESBORO, PA
9a. FACILITY NAME (If not institution, give street and number): WASHINGTON COUNTY HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: HAGERSTOWN		9c. COUNTY OF DEATH: WASHINGTON
RESIDENCE OF DECEDENT				
10a. STATE: PA	10b. COUNTY: FRANKLIN	10c. CITY, TOWN OR LOCATION: WAYNESBORO		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: POLKTOWN ROAD		10f. ZIP CODE: 17268		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MEDICAL SECRETARY		16b. KIND OF BUSINESS/INDUSTRY: NURSING HOME
17. FATHER'S NAME (First, Middle, Last): GLENN D. WINGERT			18. MOTHER'S NAME (First, Middle, Maiden Surname): ERIE P. FEIGLEY	
19a. INFORMANT'S NAME (Type/Print): LARRY J. JOHNSON		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P. O. BOX 128 ZULLINGER, PA 17256		
20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): PRICE'S CHURCH CEM. DATE: 24		20c. LOCATION — City or Town, State: WAYNESBORO, PA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James G. Bowersox		22. NAME AND ADDRESS OF FACILITY: GROVE FUNERAL HOME, INC. 50 S. BROAD ST, WAYNESBORO, PA 17268		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CEREBRAL EDEMA	WKS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. BRAIN TUMOR	1 YR
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

NONE

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Michael G. Radley MD	29c. LICENSE NUMBER: D 45936	29d. DATE SIGNED (Month, Day, Year): ▶ JUNE 21, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 23 (Type/Print): MICHAEL G. RADLEY, 1190 MT AETNA RD., HAGERSTOWN, MD 21740		
31. DATE FILED (Month, Day, Year): JUN 23 1995	32. REGISTRAR'S SIGNATURE: Julie [illegible]	

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95 20070

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ARMAND JACOT		2. DATE OF DEATH (Month, Day, Year): JUNE 15, 1995	3. TIME OF DEATH: 19:35 P M
4. SOCIAL SECURITY NUMBER: 215-13-6056	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 73 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): June 25, 1921
8. BIRTHPLACE (State or Foreign Country): Switzerland			

RESIDENCE OF DECEDENT

9a. FACILITY NAME (If not institution, give street and number): 5007 KEOKUK ST.	9b. CITY, TOWN OR LOCATION OF DEATH: BETHESDA	9c. COUNTY OF DEATH: MONTGOMERY	
10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Bethesda	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 5007 Keokuk Street	10f. ZIP CODE: 20816	10g. CITIZEN OF WHAT COUNTRY?: Switzerland	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementery/Secondary (0-12)	College (1-4 or 5+): 5+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Swiss Diplomat	16b. KIND OF BUSINESS/INDUSTRY: Embassy
17. FATHER'S NAME (First, Middle, Last): Armand Jacot		18. MOTHER'S NAME (First, Middle, Maiden Surname): Jeanne Glauser	
19a. INFORMANT'S NAME (Type/Print): Yolanda L. Jacot		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5007 Keokuk Street, Bethesda, Maryland 20816	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc. DATE: 6/17/95	20c. LOCATION — City or Town, State: Bethesda, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Michael D. Hogan M00846	22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. GUNSHOT WOUND OF NECK AND HEAD DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ ND	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ ND		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 6/15/95	28b. TIME OF INJURY: UNK M	28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO
28d. DESCRIBE HOW INJURY OCCURED: SUBJECT SHOT SELF	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): HOME	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 5007 KEOKUK ST BETHESDA, MONTGOMERY, MD	

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Donald G. Wright M.D.	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): JUNE 16, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Donald G. Wright M.D. 111 Penn Street, Baltimore, Maryland 21201		
31. DATE FILED (Month, Day, Year): JUN 19 1995	32. REGISTRAR'S SIGNATURE: Elsie Davidson Randall	

DHMH-16 Rev 1/89

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95 20071

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JERIMIAH JERRY JARICHA			2. DATE OF DEATH (Month, Day, Year): JUNE 9, 1995	3. TIME OF DEATH: 0725 M
4. SOCIAL SECURITY NUMBER: 219-37-2922	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 47 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Apr. 26, 1948	8. BIRTHPLACE (State or Foreign Country): Zimbalove
9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring		9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Gaithersburg	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 18329 Lost Knife Cir. #203		10f. ZIP CODE: 20879	10g. CITIZEN OF WHAT COUNTRY?: U.S.A

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Auto Mechanic	16b. KIND OF BUSINESS/INDUSTRY: Auto Shop	
17. FATHER'S NAME (First, Middle, Last): Chikepe Jaricha	18. MOTHER'S NAME (First, Middle, Maiden Surname): Agatha Marphosia		
19a. INFORMANT'S NAME (Type/Print): Prejadice Jaricha (Wife)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18329 Lost Knife Cir., #203, Gaithersburg MD 20879		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan Crematory DATE: 6/21	20c. LOCATION — City or Town, State: Alexandria, VA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: George R. Snowden	22. NAME AND ADDRESS OF FACILITY: SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. LYMPHOMA	MORE THAN TWO MONTHS
DUE TO (OR AS A CONSEQUENCE OF):	b. ACQUIRED IMMUNE DEFICIENCY SYNDROME	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c. RENAL FAILURE	
DUE TO (OR AS A CONSEQUENCE OF):	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one):
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Ishaak Ahmadullah	29c. LICENSE NUMBER: D43496	29d. DATE SIGNED (Month, Day, Year): ▶ 6-12-95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MOHAMMAD A. KHALID 1299-Lamberton Drive Silver Spring MD 20902		
31. DATE FILED (Month, Day, Year): JUN 20 1995	32. REGISTRAR'S SIGNATURE: Julia Blackwell Randall	

DHMH-16 Rev 1/89

95 20072

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mary Ann Johnston			2. DATE OF DEATH (Month, Day, Year): June 17, 1995	3. TIME OF DEATH: 11:00 P. M
4. SOCIAL SECURITY NUMBER: 577-20-9405	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 79 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Jan. 20, 1916	8. BIRTHPLACE (State or Foreign Country): Washington, D.C
9a. FACILITY NAME (If not institution, give street and number): Washington Adventist Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Takoma Park		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Silver Spring	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 411 University Boulevard, East		10f. ZIP CODE: 20901	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): William Andrew Connellee		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Love Morrison	
19a. INFORMANT'S NAME (Type/Print): Mary C. Graves		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11500 Galt Avenue, Wheaton, Maryland 20902	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Darlington Cemetery; DATE: 6/22	20c. LOCATION — City or Town, State: Darlington, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Andrew T. Gauthier		22. NAME AND ADDRESS OF FACILITY: Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused tha deeth. Do not enter the mode of dying, such as cerdiac or respiratory arreet, ahock, or heart failure. List only one ceuse on each line.

		Approximata Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Breast Cancer with lung and liver metastasis	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Smith S. Ho MD	29c. LICENSE NUMBER: D21900	29d. DATE SIGNED (Month, Day, Year): June 19, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SMITH S. Ho 7610 Carroll Ave. #280 Takoma Park Maryland 20912		
31. DATE FILED (Month, Day, Year): JUN 22 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

20

95 20073

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Bernice Almedia Jones			2. DATE OF DEATH (Month, Day, Year): June 19, 1995	3. TIME OF DEATH: 10:45 AM
4. SOCIAL SECURITY NUMBER: 578-22-2975	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 83 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 28, 1912	8. BIRTHPLACE (State or Foreign Country): Washington
9a. FACILITY NAME (If not institution, give street and number): 700 Laurel Court		9b. CITY, TOWN OR LOCATION OF DEATH: Mechanicsville		9c. COUNTY OF DEATH: St. Mary's

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: St. Mary's	10c. CITY, TOWN OR LOCATION: Mechanicsville	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 700 Laurel Court		10f. ZIP CODE: 20659	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Home	
17. FATHER'S NAME (First, Middle, Last): James Addison Belcher		18. MOTHER'S NAME (First, Middle, Maiden Surname): Molly Armentia Smith	
19a. INFORMANT'S NAME (Type/Print): Geraldine G. Reardon	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 700 Laurel Ct., Mechanicsville, Maryland 20659		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Crestview Cemetery DATE: June 22/95	20c. LOCATION — City or Town, State: South Hill, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Michael K Gardiner	22. NAME AND ADDRESS OF FACILITY: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE	YEARS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: ALZHEIMER'S DISEASE

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: PHILIP WOJTSKY, M.D. 6100 OXON HILL ROAD #600 OXON HILL, MARYLAND 20745	29c. LICENSE NUMBER: D-18545	29d. DATE SIGNED (Month, Day, Year): JUNE 19, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEMS (Type/Print)		
31. DATE FILED (Month, Day, Year): JUN 21 1995	32. REGISTRAR'S SIGNATURE: Julia Dawson-Randall	

DHMH-16 Rev 1/89

Philip Brooks, MD
6138 Odom Mill Road #608
Odom Hill, Maryland 20746

95-3561-021
CIP

95 20074

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DEBORA LYN KOTCH			2. DATE OF DEATH (Month, Day, Year): JUNE 17, 1995	3. TIME OF DEATH: 10:30 PM
4. SOCIAL SECURITY NUMBER: 225-23-8781	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 24 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Nov. 28, 1970	8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): JUNCTION OR ROUTES #15 & #464		9b. CITY, TOWN OR LOCATION OF DEATH: POINT OF ROCKS		9c. COUNTY OF DEATH: FREDERICK
RESIDENCE OF DECEDENT				
10a. STATE: Virginia	10b. COUNTY: Loudoun	10c. CITY, TOWN OR LOCATION: Sterling		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1513 N. Dinwiddie Street		10f. ZIP CODE: 20164		10g. CITIZEN OF WHAT COUNTRY?: U.S. of A.
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Caucasian
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12):	College (1-4 or 5 +): 7	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Certified Athletic Trainer		16b. KIND OF BUSINESS/INDUSTRY: Athletics
17. FATHER'S NAME (First, Middle, Last): Joseph M. Kotch		18. MOTHER'S NAME (First, Middle, Maiden Surname): Peggy Snedden Kotch		
19a. INFORMANT'S NAME (Type/Print): Peggy S. Kotch (mother)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as #10		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Sterling Cemetery DATE: 6-21-95		20c. LOCATION — City or Town, State: Sterling, Virginia
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ William M Simms		22. NAME AND ADDRESS OF FACILITY: Loudoun Funeral Chapel P.O. Box 1316, Leesburg, Virginia 22075		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTIPLE INJURIES

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) AT SCENE			
27. MANNER OF DEATH: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 6/19/1995	28b. TIME OF INJURY: 9:55P M	28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO	28d. DESCRIBE HOW INJURY OCCURRED: DRIVER IN AUTO/AUTO IMPACT
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): ROADWAY			28f. LOCATION (Street and Number or Rural Route Number; City or Town; State): JUNCTION OF ROUTES #15 & #454 IN FREDERICK COUNTY

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Theodore M King M.D.	29c. LICENSE NUMBER: O.C.M.E.	29d. DATE SIGNED (Month, Day, Year): ▶JUNE 19, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): THEODORE M. KING M.D. 111 Penn Street, Baltimore, Maryland 21201

31. DATE FILED (Month, Day, Year): JUL 03 1995	32. REGISTRAR'S SIGNATURE: Julia Dundas-Randall

DHMH-16 Rev 1/89

Kreps, Betty Expired 1300 6/26/95 20075

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Betty Kathleen KREPS			2. DATE OF DEATH Month: 6 Day: 26 Year: 95	3. TIME OF DEATH: 1250 M
4. SOCIAL SECURITY NUMBER: 218-50-2938	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 50 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): Dec. 31, 1944	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Washington County Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown		9c. COUNTY OF DEATH: Washington
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Williamsport		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 14314 Clear Spring Road		10f. ZIP CODE: 21795		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 11 College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Caregiver		16b. KIND OF BUSINESS/INDUSTRY: Home Health Care Services	
17. FATHER'S NAME (First, Middle, Last): William Edward Bair		18. MOTHER'S NAME (First, Middle, Maiden Surname): Betty June Rhodes		
19a. INFORMANT'S NAME (Type/Print): Joseph Walter Kreps		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14314 Clear Spring Rd. Williamsport, MD. 21795		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): St. Pauls Cemetery DATE: June 29, 1995		20c. LOCATION — City or Town, State: Clear Spring, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Mark M. Osborne		22. NAME AND ADDRESS OF FACILITY: OSBORNE FUNERAL HOME P.O.BOX 348 Williamsport, MD. 21795		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or compilcetions thet caused the death. Do not enter the mode of dying, such as cardiac or reepiratory arrest, shock, or heert failure. Liet only one ceuse on eech line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Non Hodgkins Lymphoma	4 months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially liat conditiona, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal Insufficiency
Bacteremia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, streat, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: 023623	29d. DATE SIGNED (Month, Day, Year): 6/26/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Frederic H. Kass III 1799 Howell Rd Hagerstown Md		
31. DATE FILED (Month, Day, Year): JUN 27 1995	32. REGISTRAR'S SIGNATURE	

DHMH-18 Rev 1/89

95 20076

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Melvin Lee KEEFER, Sr.

2. DATE OF DEATH: MONTH 06 DAY 28 YEAR 95

3. TIME OF DEATH: 0042 M

4. SOCIAL SECURITY NUMBER: 213-40-4806

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 52 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.

7. DATE OF BIRTH (Month, Day, Year): May 16, 1943

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): Washington County Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown

9c. COUNTY OF DEATH: Washington

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Washington

10c. CITY, TOWN OR LOCATION: Hagerstown

10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER: 278 S. Potomac Street

10f. ZIP CODE: 21740

10g. CITIZEN OF WHAT COUNTRY: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 8
College (1-4 or 5+): 0

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Petibone operator

16b. KIND OF BUSINESS/INDUSTRY: recycle center

17. FATHER'S NAME (First, Middle, Last): Lester Keefer

18. MOTHER'S NAME (First, Middle, Maiden Surname): Dorothy Mason

19a. INFORMANT'S NAME (Type/Print): Lester Keefer, Jr.

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2002 Clover Ct., Falling Waters, W.Va. 25419

20a. METHOD OF DISPOSITION: [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Bakersville Cemetery DATE 7-1-95

20c. LOCATION — City or Town, State: Bakersville, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Scott D Minnick

22. NAME AND ADDRESS OF FACILITY: MINNICH FUNERAL HOME
415 E.Wilson Blvd., Hagerstown, Md. 21740

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Bronchogenic Carcinoma — 2 Months
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible]

29c. LICENSE NUMBER: D21457

29d. DATE SIGNED (Month, Day, Year): ▶ 6/29/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ABDUL WAHEED, MD - 12821-OAK HILL AVE. HAGERSTOWN. MD

31. DATE FILED (Month, Day, Year): JUN 30 1995

32. REGISTRAR'S SIGNATURE: [illegible]

DHMH-18 Rev 1/89

95-3539=023

L.R.B.

Amended #1, 6/20/95, TKS, Allegany Co.

95 20077

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MICHAEL E. Eugene KETTERMAN II			2. DATE OF DEATH (Month, Day, Year): JUNE 17 1995	3. TIME OF DEATH: 1:48A M
4. SOCIAL SECURITY NUMBER: 197-66-8075	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 24 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): Nov. 4,1970	8. BIRTHPLACE (State or Foreign Country): Md
9a. FACILITY NAME (If not institution, give street and number): RT. 40 & RT 219 KEYSERS RIDGE.		9b. CITY, TOWN OR LOCATION OF DEATH: Accident		9c. COUNTY OF DEATH: GARRETT

RESIDENCE OF DECEDENT

10a. STATE: Pa.	10b. COUNTY: Bedford	10c. CITY, TOWN OR LOCATION: Clearville	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Rt.#3 Box 62		10f. ZIP CODE: 15535	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Roofer	16b. KIND OF BUSINESS/INDUSTRY: Construction	
17. FATHER'S NAME (First, Middle, Last): Michael Eugene Ketterman		18. MOTHER'S NAME (First, Middle, Maiden Surname): Teena Virginia Baker	
19a. INFORMANT'S NAME (Type/Print): Michael E. Ketterman	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt.#3 Box 62 Clearville, Pa. 15535		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Rest Lawn Memorial Gdns. DATE: 6/20/95	20c. LOCATION — City or Town, State: LaVale, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert C. Adams	22. NAME AND ADDRESS OF FACILITY: Merritt-Adams Funeral Home 404 Decatur St. Cumberland, Md. 21502		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. HEAD AND NECK INJURIES	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☒ Other (Specify) X ROADWAY	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): JUNE 17 95	28b. TIME OF INJURY: 1:34A M	28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO
	28d. DESCRIBE HOW INJURY OCCURED: DRIVER IN AUTO/FIXED OBJECT IMPACT		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): RT 40 & RT 219 roadway	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): GARRETT COUNTY MARYLAND.	

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Theodore M. Kaufman MD	29c. LICENSE NUMBER: O.C.M.E.	29d. DATE SIGNED (Month, Day, Year): ▶ JUNE 17 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): THEODORE M. Kaufman 111 PENN STREET, BALTIMORE, MARYLAND 21201.		
31. DATE FILED (Month, Day, Year): JUN 20 1995	32. REGISTRAR'S SIGNATURE: Julia Marchese Randall	

5

DHMH-18 Rev 1/89

Amended #6 6/21/95 MRT Montgomery County 95 20078

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Margherita Gladys Krayld				2. DATE OF DEATH (Month, Day, Year): June 20 95	3. TIME OF DEATH: 11:24 AM
4. SOCIAL SECURITY NUMBER: 217-36-8451	5. SEX: 1 ☐ M 2 XX F	6. AGE (In yrs. last birthday): 92 91 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Aug. 20, 1903	8. BIRTHPLACE (State or Foreign Country): Austria
9a. FACILITY NAME (If not institution, give street and number): Washington Adventist Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Takoma Park		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Silver Spring	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1316 Fenwick Lane, Apt. 209		10f. ZIP CODE: 20910	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+): 5+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Lawyer	16b. KIND OF BUSINESS/INDUSTRY: Legal
17. FATHER'S NAME (First, Middle, Last): Helmich Muck		18. MOTHER'S NAME (First, Middle, Maiden Surname): Augusta (unavailable)
19a. INFORMANT'S NAME (Type/Print): Rande K. Joiner	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1350 Connecticut Avenue, N.W., Suite 850, Wash., D.C. 20036	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Chesapeake Crematory	DATE: 6/21 — 20c. LOCATION — City or Town, State: Beltsville, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ellen W. Rapp	22. NAME AND ADDRESS OF FACILITY: Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, MD 20910	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or reepiretory srrest, shock, or heert failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. arteriosclerotic Heart Disease	4 yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M
	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John Lauber MD	29c. LICENSE NUMBER: D0857[illegible]	29d. DATE SIGNED (Month, Day, Year): ▶ June 20 95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John Lauber MD 8218 Wisconsin Ave Bethesda

31. DATE FILED (Month, Day, Year): JUN 21 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

25

95 20079

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Alice Clayton Koger			2. DATE OF DEATH (Month, Day, Year): JUNE, 20 1995	3. TIME OF DEATH: 2:15 pm
4. SOCIAL SECURITY NUMBER: 226-30-1508	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 67 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 22, 1928	8. BIRTHPLACE (State or Foreign Country): Virginia

9a. FACILITY NAME (If not institution, give street and number): Suburban Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda	9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Rockville	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 11213 Ashley Drive	10f. ZIP CODE: 20852	10g. CITIZEN OF WHAT COUNTRY?: USA	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cosmetologist	16b. KIND OF BUSINESS/INDUSTRY: Cosmetics	

17. FATHER'S NAME (First, Middle, Last): Morris Jarrett	18. MOTHER'S NAME (First, Middle, Maiden Surname): Susie Adams
19a. INFORMANT'S NAME (Type/Print): Cecil M. Koger	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11213 Ashley Drive Rockville, Maryland 20852

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Parklawn Cemetery DATE: 6/23/95	20c. LOCATION — City or Town, State: Rockville, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Andrew J. Cole	22. NAME AND ADDRESS OF FACILITY: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Respiratory Failure	Immediate
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Pneumonia	3 days
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Chronic Obstructive Kidney Disease	Long-Standing
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Depression

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☒ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Ira Paul Kroffing MD	29c. LICENSE NUMBER: 021435	29d. DATE SIGNED (Month, Day, Year) ▶ 6-20-95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ira Paul Kroffing 2101 Medical Park Dr. Silver Spring Md 20910		
31. DATE FILED (Month, Day, Year): JUN 23 1995	32. REGISTRAR'S SIGNATURE: Julie Davidson Randall	

DHMH-16 Rev 1/89

95 20080

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Blanche Kossow				2. DATE OF DEATH (Month, Day, Year): June 16 1995	3. TIME OF DEATH: 3:05 pM
4. SOCIAL SECURITY NUMBER: 050-05-6805	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 84 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): FEB. 5, 1911	8. BIRTHPLACE (State or Foreign Country): NEW YORK
9a. FACILITY NAME (If not institution, give street and number): SUBURBAN HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: BETHESDA		9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE: FLORIDA	10b. COUNTY: MARGATE	10c. CITY, TOWN OR LOCATION: MARGATE	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 370 N W 76TH. AVENUE		10f. ZIP CODE: 33063-4893	10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER	16b. KIND OF BUSINESS/INDUSTRY: OWN HOME	
17. FATHER'S NAME (First, Middle, Last): JULIUS SIMON		18. MOTHER'S NAME (First, Middle, Maiden Surname): ADA "UNKNOWN"	
19a. INFORMANT'S NAME (Type/Print): DEBRA KOSSOW ROSENBLUM (DAUGHTER)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 414 PITT MEWS - ALEXANDRIA, VIRGINIA 22314		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place): ADAS ISRAEL CONG. CEMETERY	DATE: 6/18	20c. LOCATION — City or Town, State: WASHINGTON, D.C.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert L Zamansky	22. NAME AND ADDRESS OF FACILITY: ZANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MD. 20852		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not entar the mode of dying, such as cardiac or reapiratory arreat, shock, or haart failure. List only one ceuse on aach line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel diseese or condition resulting in death) →	a. Septic shock	3 days
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initiated events resulting in death) LAST	b. Perforation Caecum	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. faecal impaction	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: ☑ 1 Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, ferm, atreet, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
☑ 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Amendhirattta MD.	29c. LICENSE NUMBER: D38262	29d. DATE SIGNED (Month, Day, Year): ▶ June 17, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ANURITA MENDHIRATTA 2401 Research BLVD SUITE 340 Rockville MD 20854.		
31. DATE FILED (Month, Day, Year): JUN 23 1995	32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall	

DHMH-16 Rev 1/89

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95 20081

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Keum-Joo Koh			2. DATE OF DEATH (Month, Day, Year): June 16, 1995	3. TIME OF DEATH: 9:20 PM
4. SOCIAL SECURITY NUMBER: 213-94-8052	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 79 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): March 27, 1916
8. BIRTHPLACE (State or Foreign Country): Korea				
9a. FACILITY NAME (If not institution, give street and number): Suburban Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda	9c. COUNTY OF DEATH: Montgomery		

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Potomac	10d. INSIDE CITY LIMITS? ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 9713 Meyer Point Drive	10f. ZIP CODE: 20854	10g. CITIZEN OF WHAT COUNTRY?: Korean	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Korean

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY: Home	
17. FATHER'S NAME (First, Middle, Last): Eun Koh	18. MOTHER'S NAME (First, Middle, Maiden Surname): Unknown Lee		
19a. INFORMANT'S NAME (Type/Print): Steven Park	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7509 Leesburg Place, Bethesda, Maryland 20817		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Norbeck Memorial Park	DATE: 6/19	20c. LOCATION — City or Town, State: Olney, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Andrew T. Gunthner	22. NAME AND ADDRESS OF FACILITY: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiorespiratory arrest	1 day
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Adult Respiratory distress Syndrome	3 weeks
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: G. Gupta	29c. LICENSE NUMBER: MD 46398	29d. DATE SIGNED (Month, Day, Year): ▶ June 18th, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ghanshyam Gupta, M.D. 121 Congressional Lane # 409, Rockville MD 20852

31. DATE FILED (Month, Day, Year): JUN 19 1995	32. REGISTRAR'S SIGNATURE: Julia Strickson-Randall

DHMH-16 Rev 1/89

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95-3508-031
B.K.S

95 20082

ITEMS: 23 PART I, 27, MEO FILM G-728 10/27/95 t.t

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
STEPHEN	GARY	KERMAN	JUNE 14, 1995	1645 PM

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
577-04-7938	1 [X] M 2 [ ] F	28 YRS.			Feb 17 1967	Washington D.C.

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
11013 BALANTRE LANE	POTOMAC	MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MD	Montgomery	Potomac	1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
11013 Balantre Lane	20854	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] YES 2 [X] NO	1 [ ] YES 2 [X] NO Specify:	Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
	1	general contracter	own business

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Edward Kerman	Mary Lynn Winston

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Edward Kerman	11013 Balantre Lane Potomac MD 20854

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	King David Memorial Gardens	6-16	Falls Church VA

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
[signature]	Edward Sagel Funeral Direction 1091 Rockville Pike Rockville MD 20852

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. NO ANATOMIC OR TOXICOLOGIC CAUSE OF DEATH	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [X] YES 2 [ ] NO	1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
XX YES 2 [ ] NO	HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home XX Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 XX Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [X] Pending Investigation 6 [ ] Could not be determined		M	1 [ ] YES 2 [ ] NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29e. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] M.D.	O.C.M.E	JUNE 15, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	
MARYANN D. KOROA	111 Penn Street, Baltimore, Maryland 21201

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 20 1995	[signature]

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 20083

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): NEIL HARRY KNIPE			2. DATE OF DEATH (Month, Day, Year): JUNE 16, 1995	3. TIME OF DEATH: 2:15 P M
4. SOCIAL SECURITY NUMBER: 225.10.1784	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 89 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): AUG. 19, 1905	8. BIRTHPLACE (State or Foreign Country): WEST VIRGINIA
9a. FACILITY NAME (If not institution, give street and number): CARRIAGE NURSING HOME		9b. CITY, TOWN OR LOCATION OF DEATH: SILVER SPRING		9c. COUNTY OF DEATH: MONT.
RESIDENCE OF DECEDENT				
10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION: WASHINGTON D.C.		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1221 MASSACHUSETTS AVE. N.W. APT.901		10f. ZIP CODE: 20005		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4 or 5 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ELECTRICIAN	16b. KIND OF BUSINESS/INDUSTRY: ELECTRICAL		
17. FATHER'S NAME (First, Middle, Last): HARRY KNIPE		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY UNKNOWN		
19a. INFORMANT'S NAME (Type/Print): NORMAN NEIL KNIPE		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1221 MASSACHUSETTS AVE. N.W. APT. 901 WASHINGTON DC		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): NATIONAL MEM. PARK	DATE: 6/20	20c. LOCATION — City or Town, State: FALLS CHURCH, VA.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Leah M. Peters	22. NAME AND ADDRESS OF FACILITY: JOS GAWLERS SONS INC. 5130 WI AVE N.W. WASHINGTON, D.C. 20016			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Urosepsis (Septicemia) DUE TO (OR AS A CONSEQUENCE OF):	4 days
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b.	Obstructive Uropathy (Prostate) DUE TO (OR AS A CONSEQUENCE OF):	2-3 years
c.	DUE TO (OR AS A CONSEQUENCE OF):	
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] ND
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Paul T. Noone MD /Dupont	29c. LICENSE NUMBER: D07471	29d. DATE SIGNED (Month, Day, Year): ▶ JUNE 16, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PAUL T. NOONE M.D. 50 EDMONSTON DRIVE # 207 ROCKVILLE, MD 20852

31. DATE FILED (Month, Day, Year): JUN 20 1995	32. REGISTRAR'S SIGNATURE: Julia Strickland Randall

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GEORGE J. KOBACK					2. DATE OF DEATH (Month, Day, Year): JUNE 19 1995	3. TIME OF DEATH: 224 P M
4. SOCIAL SECURITY NUMBER: 579-26-7689	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 71 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): April 7, 1924	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): Suburban Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda			9c. COUNTY OF DEATH: Montgomery
RESIDENCE OF DECEDENT						
10a. STATE: Maryland	10b. COUNTY: Montgomery		10c. CITY, TOWN OR LOCATION: Bethesda			10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 5102 Benton Avenue			10f. ZIP CODE: 20814			10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 5+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Senior Program Analyst			16b. KIND OF BUSINESS/INDUSTRY: U.S. Government
17. FATHER'S NAME (First, Middle, Last): John Michael Koback			18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Kostishak			
19a. INFORMANT'S NAME (Type/Print): Anna M. Koback			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5102 Benton Avenue, Bethesda, Maryland 20814			
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Gate of Heaven Cemetery DATE: June 23, 1995			20c. LOCATION — City or Town, State: Silver Spring, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert Funk M00198			22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD 20814-3501			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or reepiratory arrest, shock, or heart failure. List only one ceuse on eech line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel diseese or condition resulting in death) →	a. Cardio pulmonary Arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Coronary Artery Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: T. Goldbaum

29c. LICENSE NUMBER: MD-D-30885

29d. DATE SIGNED (Month, Day, Year): 2/14/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Thomas Goldbaum, M.D. 5530 Wisconsin Avenue, Chevy Chase, Maryland 20815

31. DATE FILED (Month, Day, Year): JUN 22 1995

32. REGISTRAR'S SIGNATURE: Julie Davidson Randall

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): PAUL KLOSE		2. DATE OF DEATH (Month, Day, Year): May 26, 1995	3. TIME OF DEATH: 3:28A. M
4. SOCIAL SECURITY NUMBER: 340-05-0805	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 90 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): January 25, 1905
8. BIRTHPLACE (State or Foreign Country): Germany			
9a. FACILITY NAME (If not institution, give street and number): St. Mary's Nursing Center	9b. CITY, TOWN OR LOCATION OF DEATH: Leonardtown	9c. COUNTY OF DEATH: St. Mary's	
RESIDENCE OF DECEDENT			
10a. STATE: Maryland	10b. COUNTY: St. Mary's	10c. CITY, TOWN OR LOCATION: Leonardtown	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: P.O. Box 518	10f. ZIP CODE: 20650	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 4; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Baker	16b. KIND OF BUSINESS/INDUSTRY: Food Service	
17. FATHER'S NAME (First, Middle, Last): Nickolas Klose	18. MOTHER'S NAME (First, Middle, Maiden Surname): Gertrude (unknown)		
19a. INFORMANT'S NAME (Type/Print): Roger Klose	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1851 Gulf Blvd., Belleair Beach, Florida 34634		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan Crematory DATE: 5/29	20c. LOCATION — City or Town, State: Alexandria, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Edward N. Brinsfield, Jr., M00052	22. NAME AND ADDRESS OF FACILITY: Brinsfield Funeral Home, P.A. 59 N. Washington St., Leonardtown, MD 20650-0279		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardiopulmonary Failure — DUE TO (OR AS A CONSEQUENCE OF):	hr.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST: b.	Sepsis — DUE TO (OR AS A CONSEQUENCE OF):	10 days
c.	Urosepsis — DUE TO (OR AS A CONSEQUENCE OF):	10 days
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery DE, Myocardial Ischemia
Lymphoma, Pernicious Anemia

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO N.A.

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: J. P. Barbor M.D. | 29c. LICENSE NUMBER: D06419 | 29d. DATE SIGNED (Month, Day, Year): 5/26/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. Patrick Barbor, M.D., Medical Arts Building, Leonardtown, Maryland 20650

31. DATE FILED (Month, Day, Year): JUN - 5 1995 | 32. REGISTRAR'S SIGNATURE: Julia Bassett Hardesty

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Martha Lee Knott			2. DATE OF DEATH (Month, Day, Year): May 30, 1995	3. TIME OF DEATH: 2:55 p. M
4. SOCIAL SECURITY NUMBER: 217-18-8484	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 71 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): June 21, 1923	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Star Route Box 98, Manor Rd. (Home)		9b. CITY, TOWN OR LOCATION OF DEATH: Chaptico		9c. COUNTY OF DEATH: St. Mary's
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: St. Mary's	10c. CITY, TOWN OR LOCATION: Chaptico		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Star Route Box 98, Manor Rd.		10f. ZIP CODE: 20621		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th grade; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker		16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): John Edward Ellis, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Renie Elizabeth Long		
19a. INFORMANT'S NAME (Type/Print): Joyce Ann Cusic		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Star Route Box 28, Chaptico, Maryland 20621		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Christ Church Cemetery DATE: 6/3/95		20c. LOCATION — City or Town, State: Chaptico, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Michael K. Gardiner		22. NAME AND ADDRESS OF FACILITY: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardiopulmonary Failure	hrs.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b.	Cardiomyopathy	1 yr.
DUE TO (OR AS A CONSEQUENCE OF): c.	Carcinoma of Lung	18 mo
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO N/A

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
J. Patrick Jarboe, M.D.	D 06419	5-31-95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. J. Patrick Jarboe, M.D. Leonardtown, Maryland 20650

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN -2 1995	Julia Davidson-Randall

DHMH-16 Rev 1/89

95 20087

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEOENT'S NAME (First, Middle, Last): Ntinglet Baby boy Prince Agee Kemngang
2. DATE OF DEATH (Month, Day, Year): 6/14/95
3. TIME OF OEATH: 2:40 A M
4. SOCIAL SECURITY NUMBER:
5. SEX: 1 X M 2 ☐ F
6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): 06/14/95
8. BIRTHPLACE (State or Foreign Country): Prince Georges
9a. FACILITY NAME (If not institution, give street and number): Prince Georges Hospital Center
9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly, Maryland
9c. COUNTY OF DEATH: Prince Georges

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Prince Georges
10c. CITY, TOWN OR LOCATION: Glenn Dale
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 5906 Chivarly Court
10f. ZIP CODE: 20769
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO — IF YES, GIVE WAR OR DATES
13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. OECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0 — College (1-4 or 5+):
16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): none
16b. KIND OF BUSINESS/INDUSTRY: none
17. FATHER'S NAME (First, Middle, Last): Charles N. Kemngang
18. MOTHER'S NAME (First, Middle, Maiden Surname): Beneditte N. Ntinglet
19a. INFORMANT'S NAME (Type/Print): Mother
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5906 Chivarly Court, Glenn Dale, Maryland
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) by hosp
20b. PLACE AND DATE OF DISPOSITION (Neme of cemetery, cremetory or other piece): DATE
20c. LOCATION — City or Town, State: 20769
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶
22. NAME ANO ADDRESS OF FACILITY

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory erreat, ahock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Finel disease or condition resulting in death) →
a. 21-22 weeks male infant
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immedieta cause. Enter UNDERLYING CAUSE (Diseese or injury that initieted eventa resulting in death) LAST
b. Previable
DUE TO (OR AS A CONSEQUENCE OF):
c.
OUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Othar significant conditiona contributing to death but not resulting in the underlying cause givan in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF 0EATH? 1 ☐ YES 2 X NO

25. WAS CASE REFERREO TO MEOICAL EXAMINER? 1 ☐ YES 2 X NO
26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 X Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCUREO
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEOICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Duke MD
29c. LICENSE NUMBER: D34 229
29d. DATE SIGNED (Month, Day, Year) ▶ 6/14/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PG Hospital
31. DATE FILED (Month, Day, Year): JUL 06 1995
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

95 20088

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DOROTHY M. LEASE					2. DATE OF DEATH (Month, Day, Year): June 11, 1995	3. TIME OF DEATH: 6:00 P M
4. SOCIAL SECURITY NUMBER: 235-54-8253	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 80 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Feb 25, 1915	8. BIRTHPLACE (State or Foreign Country): WV
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland		9c. COUNTY OF DEATH: Allegany	
RESIDENCE OF DECEDENT						
10a. STATE: MD	10b. COUNTY: Allegany		10c. CITY, TOWN OR LOCATION: Cresaptown		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO	
10e. STREET AND NUMBER: Brant Road			10f. ZIP CODE: 21502		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4 or 5+):			18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker		18b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Robert C. Simpson			16. MOTHER'S NAME (First, Middle, Maiden Surname): Mary E. Anderson			
19a. INFORMANT'S NAME (Type/Print): Baker Lease			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt 3, Box 16-B Rawlings, MD 21557			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Zion Cemetery 6/14/95	DATE	20c. LOCATION — City or Town, State: Keyser, WV 26726	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]			22. NAME AND ADDRESS OF FACILITY: Rotruck-Smith Funeral Home 85 South Main Street Keyser, WV 26726			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Carcinoma of the Lungs with Bone Metastasis	14 Days
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD CAD

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☑ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]

29c. LICENSE NUMBER: D 14865

29d. DATE SIGNED (Month, Day, Year): ▶ June 11, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. R. Barrera, Memorial Hospital Medical Bldg., Cumberland, MD 21502

31. DATE FILED (Month, Day, Year): JUN 19 1995

32. REGISTRAR'S SIGNATURE: [signature]

6

DHMH-16 Rev 1/89

95 20089

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARY LEGGO			2. DATE OF DEATH: MONTH June DAY 17, YEAR 1995	3. TIME OF DEATH: 7:55 P. M
4. SOCIAL SECURITY NUMBER: 177-22-5419	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 84 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): September 10, 1910	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): Southern Maryland Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Clinton		9c. COUNTY OF DEATH: Prince George's

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Suitland	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 4661 Bromley Avenue		10f. ZIP CODE: 20746	10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY: Domestic	
17. FATHER'S NAME (First, Middle, Last): John Petchel		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Staruch	
19a. INFORMANT'S NAME (Type/Print): Monica L. Young	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3114 Waterside Lane Alexandria, Virginia 22309		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Calvary Cemetery DATE: June 23, 1995	20c. LOCATION — City or Town, State: Drums, Pennsylvania	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Donald V Borgwardt	22. NAME AND ADDRESS OF FACILITY: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Md. 20705		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ACUTE CONGESTIVE HEART FAILURE	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ASCVD	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CORONARY ARTERY DISEASE, EMPHYSEMA

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]

29c. LICENSE NUMBER: D19431

29d. DATE SIGNED (Month, Day, Year): ▶ 6/17/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Frank M. Ryan M.D. 6188 Oxon Hill Rd #610 Oxon Hill Md 20745

31. DATE FILED (Month, Day, Year): JUN 20 1995

32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DHMH-16 Rev 1/89

95 20090

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Louis A. Lozupone			2. DATE OF DEATH (Month, Day, Year): June 19 1995	3. TIME OF DEATH: 12:30 A.M.
4. SOCIAL SECURITY NUMBER: 577-07-8477	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 79 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): March 17, 1916	8. BIRTHPLACE (State or Foreign Country): Washington, D.C
9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince Georges	10c. CITY, TOWN OR LOCATION: Takoma Park	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1519 Elson Street		10f. ZIP CODE: 20912	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Police Officer	16b. KIND OF BUSINESS/INDUSTRY: District of Columbia Government	
17. FATHER'S NAME (First, Middle, Last): Constantino Lozupone		18. MOTHER'S NAME (First, Middle, Maiden Surname): Consiglia Prencipe	
19a. INFORMANT'S NAME (Type/Print): Gilda N. Lozupone	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1519 Elson StreetTakoma Park, Maryland 20912		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Fort Lincoln Cemetery DATE: 5-22-95	20c. LOCATION — City or Town, State: Brentwood, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: Hines-Rinaldi Funeral Home 20904 11800 NewHampshireAveSilverSpring, M.D.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CONGESTIVE HEART FAILURE	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. CORONARY DISEASE	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE
HYPERTENSION

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D24819	29d. DATE SIGNED (Month, Day, Year): 6/19/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Bruce Zinsmeister, MD 8830 Cameron Street Silver Spring, Maryland 20910

31. DATE FILED (Month, Day, Year): JUN 22 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10

95 20091

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GEORGE WASHINGTON LEOPARD		2. DATE OF DEATH (Month, Day, Year): JUNE 1 1995	3. TIME OF DEATH: 02.20 M
4. SOCIAL SECURITY NUMBER: 435-07-7946	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 85 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): January 17, 1910 — 8. BIRTHPLACE (State or Foreign Country): Louisiana
9a. FACILITY NAME (If not institution, give street and number): St. Mary's Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Leonardtown	9c. COUNTY OF DEATH: St. Mary's

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: St. Mary's	10c. CITY, TOWN OR LOCATION: St. Mary's City	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: Box 225		10f. ZIP CODE: 20683	10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): 6	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Electrical Engineer	16b. KIND OF BUSINESS/INDUSTRY: U.S. Navy/Defense	
17. FATHER'S NAME (First, Middle, Last): John L. Leopard Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Eulalie Reynolds	
19a. INFORMANT'S NAME (Type/Print): George S. Leopard	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 840 East Avenue, Rochester, New York 14607		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Trinity Episcopal — DATE: 6/5/95	20c. LOCATION — City or Town, State: St. Mary's City, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Edward N. Brinsfield, Jr. M00052	22. NAME AND ADDRESS OF FACILITY: Brinsfield Funeral Home, P.O. Box 279, Leonardtown, Maryland 20650		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardio Pulmonary Failure	hrs.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b.	Aspiration Pneumonia	day
DUE TO (OR AS A CONSEQUENCE OF): c.	Cerebral Thrombosis	yrs
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Depression

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO N/D

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) — 28b. TIME OF INJURY — 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO — 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) — 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: J. P. Jarboe MD — 29c. LICENSE NUMBER: D0 6419 — 29d. DATE SIGNED (Month, Day, Year): 6-2-95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. Patrick Jarboe, M.D. Medical Arts Bldg., Leonardtown, Maryland 20650

31. DATE FILED (Month, Day, Year): JUN 05 1995 — 32. REGISTRAR'S SIGNATURE: Gabriel Chandler-Randall

DHMH-16 Rev 1/89

95-3716-041
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ITEMS: 23 PART I, 27, PER MEO FILM G-726 8/1/95 t.t

95 20092

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Christopher Bryan Miller				2. DATE OF DEATH (Month, Day, Year): June 25 1995	3. TIME OF DEATH: 0357 M
4. SOCIAL SECURITY NUMBER: 212-43-4503	5. SEX: XX 1 M 2 F	6. AGE (In yrs. last birthday): YRS.	IF UNDER 1 YEAR: MONTHS 11 DAYS 21 / IF UNDER 24 HRS.: HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year): July 17, 1994	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Easton		9c. COUNTY OF DEATH: Talbot
RESIDENCE OF DECEDENT					
10a. STATE: Maryland	10b. COUNTY: Queen Anne's	10c. CITY, TOWN OR LOCATION: Stevensville			10d. INSIDE CITY LIMITS? XX 1 YES 2 NO
10e. STREET AND NUMBER: 402 Falcon Court		10f. ZIP CODE: 21666		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: XX Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XX NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 XX NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5 +)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): Bryan D. Miller		18. MOTHER'S NAME (First, Middle, Maiden Surname): Laura Lynn Jewell			
19a. INFORMANT'S NAME (Type/Print): Laura L. Miller		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P. O. Box 1084 Stevensville, Md. 21666			
20a. METHOD OF DISPOSITION: XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Stevensville Cemetery DATE: June 27, 1995	20c. LOCATION — City or Town, State: Stevensville, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Kirk A. Helfenbein		22. NAME AND ADDRESS OF FACILITY: Tom Helfenbein Funeral Homes, P.A. 106 Shamrock Rd., Chester, Md. 21619			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SUDDEN INFANT DEATH SYNDROME

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 X YES 2 NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 X DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)		
27. MANNER OF DEATH: 1 XX Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 YES 2 NO
	28d. DESCRIBE HOW INJURY OCCURED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Theodore M. Kyg MD	29c. LICENSE NUMBER: O.C.M.E.	29d. DATE SIGNED (Month, Day, Year): ▶ June 26 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): THEODORE M. KYG	111 Penn Street, Baltimore, Maryland 21201	
31. DATE FILED (Month, Day, Year): JUL 03 1995	32. REGISTRAR'S SIGNATURE: Julia Brooks-Randall	

DHMH-16 Rev 1/89

95 20093

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Charles Murray			2. DATE OF DEATH (Month, Day, Year): June 20, 1995	3. TIME OF DEATH: 2384 M
4. SOCIAL SECURITY NUMBER: 578-58-3271	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 48 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): MAY 4, 1947	8. BIRTHPLACE (State or Foreign Country): WASHINGTON, DC
9a. FACILITY NAME (If not institution, give street and number): PRINCE GEORGE GENERAL HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: CHEVERLY	9c. COUNTY OF DEATH: PRINCE GEORGE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: PRINCE GEORGE	10c. CITY, TOWN OR LOCATION: CAPITOL HEIGHTS	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: #603 64TH AVENUE		10f. ZIP CODE: 20743	10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES	13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12):	College (1-4 or 5+): 1 YEAR	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): TRUCK DRIVER	16b. KIND OF BUSINESS/INDUSTRY: PRIVATE INDUSTRY
17. FATHER'S NAME (First, Middle, Last): UNKNOWN		18. MOTHER'S NAME (First, Middle, Maiden Surname): COTURNER WIDEMAN	
19a. INFORMANT'S NAME (Type/Print): CAROLYN H. MURRAY		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): #603 64TH AVENUE, CAPITOL HEIGHTS, MARYLAND 20743	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): HARMONY MEMORIAL PARK — DATE: 6/24/95	20c. LOCATION — City or Town, State: HYATTSVILLE, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Lydia C Thornton Johnson — LYDIA C. THORNTON JOHNSON M00583		22. NAME AND ADDRESS OF FACILITY: THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MD. 20640	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Hypertensive arteriosclerotic cardiovascular disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Asthma, Obesity

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Augusto P. Ponciano MD	29c. LICENSE NUMBER: D21730	29d. DATE SIGNED (Month, Day, Year): June 20, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Augusto P. Rodriguez MD 5009 Rayburn Ct Cheverly MD 20785		
31. DATE FILED (Month, Day, Year): JUN 22 1995	32. REGISTRAR'S SIGNATURE: Debra Theodore-Randall	

DHMH-18 Rev 1/89

95 20094

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BETTY MADALENE MILLER			2. DATE OF DEATH: MONTH JUNE DAY 25, YEAR 1995	3. TIME OF DEATH: 9:45 P M
4. SOCIAL SECURITY NUMBER: 218-24-9663	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 66 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): FEB. 20, 1929	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): WILLIAMSPORT NURSING HOME		9b. CITY, TOWN OR LOCATION OF DEATH: WILLIAMSPORT		9c. COUNTY OF DEATH: WASHINGTON

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: WASHINGTON	10c. CITY, TOWN OR LOCATION: BOONSBORO	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 27 FORD AVENUE		10f. ZIP CODE: 21713	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER	16b. KIND OF BUSINESS/INDUSTRY: OWN HOME	
17. FATHER'S NAME (First, Middle, Last): IRA J. STINE		18. MOTHER'S NAME (First, Middle, Maiden Surname): CATHERINE FORSYTHE	
19a. INFORMANT'S NAME (Type/Print): CARL L. MILLER	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 27 FORD AVENUE, BOONSBORO, MARYLAND 21713		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ROSE HILL CEMETERY 6/28/95	20c. LOCATION — City or Town, State: HAGERSTOWN, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John H. Bast Jr.	22. NAME AND ADDRESS OF FACILITY: BAST FUNERAL HOME	7606 Old National Pike Boonsboro, MD 21713	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. METASTATIC BREAST CARCINOMA	5 YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Ted Howe MD	29c. LICENSE NUMBER: D 33700	29d. DATE SIGNED (Month, Day, Year): JUNE 26, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): TED E. HOWE, M.D., 154 NORTH ARTIZAN STREET, WILLIAMSPORT, MD 21795

31. DATE FILED (Month, Day, Year): JUN 26 1995	32. REGISTRAR'S SIGNATURE: Julie Davidson Randall

DHMH-16 Rev 1/89

95 20095

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Margaret Rebekah MULLER			2. DATE OF DEATH: Month June, Day 27, Year 1995	3. TIME OF DEATH: 8:55 A M
4. SOCIAL SECURITY NUMBER: 170-36-6883	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 51 YRS. (If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.)	7. DATE OF BIRTH (Month, Day, Year): July 10, 1943	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): 17926 College Road		9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown		9c. COUNTY OF DEATH: Washington

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Hagerstown	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 17926 College Road		10f. ZIP CODE: 21740	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 6		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): librarian	16b. KIND OF BUSINESS/INDUSTRY: school
17. FATHER'S NAME (First, Middle, Last): Edmund C. Newton		18. MOTHER'S NAME (First, Middle, Maiden Surname): Rebekah Troxler	
19a. INFORMANT'S NAME (Type/Print): Kenneth Muller		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17926 College Road, Hagerstown, Md.	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Hagerstown Crematory; DATE: 6-28-95	20c. LOCATION — City or Town, State: Hagerstown, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Scott Minnich		22. NAME AND ADDRESS OF FACILITY: MINNICH FUNERAL HOME 415 E.Wilson Blvd.,Hagerstown,Md.21740	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the desth. Do not snter the mods of dying, such as cardiac or respiratory srrest, ehock, or heert feilure. Liet only one ceuse on esch lins.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Breast Cancer	1 year
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☑ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Michael J. McCormack	29c. LICENSE NUMBER: D41667	29d. DATE SIGNED (Month, Day, Year): 6-28-95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Michael J. McCormack 1799 Howell Rd. Hagerstown, MD. 21740		
31. DATE FILED (Month, Day, Year): JUN 29 1995	REGISTRAR'S SIGNATURE: Julia Wilson Reed	

DHMH-16 Rev 1/89

Amended #6,7; 6/20/95, NBS, Allegany Co.

95 20096

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
James	William	Miller	June 16, 1995	11:50 a M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
214-05-7187	1 [X] M 2 [ ] F	83 YRS.			Aug 29, 1911	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Devlin Manor Nursing Home	Cumberland	Allegany

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MD	Allegany	Cumberland	1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
20 Potomac Street	21502	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES?	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	1 [ ] YES 2 [X] NO Specify:	Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12		Retired Pipefitter	Textile

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Gilbert B. Miller	Jenny G. (Viney)

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
James F. Miller	5 Clement Street; Cumberland, MD 21502

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Sunset Memorial Park	06/19	Cumberland, MD 21502

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ James F Scarpelli	Scarpelli Funeral Home Cumberland, MD 21502

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Alzheimer's disease	4yr
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X]

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [ ] YES 2 [X] NO	HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined		M	1 [ ] YES 2 [ ] NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)

1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.

2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
A J Bellini MD	D17565	▶ June 16 95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

955 Frederick St Cumberland, MD. A J Bellini MD. June 16 95

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 20 1995	Kathleen Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6

95 20097

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HARRY WILLIAM MARTZ			2. DATE OF DEATH (Month, Day, Year): JUNE 8 1995	3. TIME OF DEATH: 11:55 P M
4. SOCIAL SECURITY NUMBER: 705-09-2935	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 91 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): March 6, 1904	8. BIRTHPLACE (State or Foreign Country): HYNDMAN, PA
9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND		9c. COUNTY OF DEATH: ALLEGANY

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: ALLEGANY	10c. CITY, TOWN OR LOCATION: CORRIGANVILLE	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: ROUTE 35, P. O. BOX 161		10f. ZIP CODE: 21524	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 — College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SIGNAL MAINTENANCE	16b. KIND OF BUSINESS/INDUSTRY: RAILROAD	
17. FATHER'S NAME (First, Middle, Last): FRANK MARTZ		18. MOTHER'S NAME (First, Middle, Maiden Surname): ELIZABETH GELLER	
19a. INFORMANT'S NAME (Type/Print): ALICEFAYE LEYDIG	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): R. D. 1, BUFFALO MILLS, PA 15534		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): MILLIGANS COVE CEMETERY JUNE 12 1995	20c. LOCATION — City or Town, State: RD, BUFFALO MILLS, PA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Harvey H Zeigler	22. NAME AND ADDRESS OF FACILITY: HARVEY H. ZEIGLER FUNERAL HOME HYNDMAN, PA 15545-0636		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pulmonary Edema & Heart Failure — DUE TO (OR AS A CONSEQUENCE OF):	8 DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. — DUE TO (OR AS A CONSEQUENCE OF):	
	c. — DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) — 28b. TIME OF INJURY M — 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO — 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
	D07164	JUNE 12, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. JACK W. HARVEY, M.D., 925 SETON DRIVE, CUMBERLAND, MD 21502

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 14 1995	Julia Lawrence-Randall

6

DHMH-18 Rev 1/89

95 20098

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)	2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
LEONA IDA MOWER	JUN 11, 1995	9:42 A. M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
214-62-3972	1 ☐ M 2 ☒ F	86 YRS.			Jul 10 1908	MD

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
607 ST. MARY'S AVENUE	CUMBERLAND	ALLEGANY

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MD	Allegany	Cumberland	1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
607 St Mary's Avenue	21502	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES?	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	1 ☐ YES 2 ☒ NO Specify:	Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12		homemaker	own home

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
William H. Lashley	Hilda Winter

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Grace L. Rinker	4853 Centurian Way; Greenacres, FL 33463

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Hillcrest Burial Park	06/15	Cumberland, MD 21502

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
James J Scarpelli	Scarpelli Funeral Home Cumberland, MD 21502

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Hypertension Atherosclerotic Heart Disease DUE TO (OR AS A CONSEQUENCE OF):	40 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. Paul Pun M.D. June 11, 1995	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☒ YES released 2 ☐ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
A Bollino MD	D17565	June 12, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DR. ANTHONY BOLLINO, M.D.; 955 FREDERICK STREET; CUMBERLAND, MD 21502

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 13 1995	Julia Henderson-Randall

6

OHMH-16 Rev 1/89

95 20099

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN MOSBY			2. DATE OF DEATH: MONTH JUNE DAY 18, YEAR 1995	3. TIME OF DEATH: 4:25 AM
4. SOCIAL SECURITY NUMBER: 577-20-9091	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 2, 1921	8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): Prince Georges Hospital Center		9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly		9c. COUNTY OF DEATH: Prince Georges

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince Georges	10c. CITY, TOWN OR LOCATION: Beltsville	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3317 Major Denton Drive		10f. ZIP CODE: 20705	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Supervisor	16b. KIND OF BUSINESS/INDUSTRY: U.S. Government	
17. FATHER'S NAME (First, Middle, Last): John W. Mosby		18. MOTHER'S NAME (First, Middle, Maiden Surname): Lauvinia Minor	
19a. INFORMANT'S NAME (Type/Print): Marsha Mosby Lacey		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4003 Beltsville Rd., #21, Beltsville, MD 20705	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Baltimore-Washington Crem. DATE: 6/23/95	20c. LOCATION — City or Town, State: Laurel, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	End Stage Renal Disease	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Diabetes Mellitus	
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peripheral Vascular Disease
Congestive heart Failure

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D38687	29d. DATE SIGNED (Month, Day, Year): ▶ 6/21/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): STEPHEN J KATZ PRINCE GEORGE'S HOSP CENTER

31. DATE FILED (Month, Day, Year): JUN 23 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

10

DHMH-18 Rev 1/89

95 20100

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Anton J. Matijevic			2. DATE OF DEATH (Month, Day, Year): June 17 1995	3. TIME OF DEATH: 9:37 A M
4. SOCIAL SECURITY NUMBER: 338-22-8492	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 68 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): June 6 1927	8. BIRTHPLACE (State or Foreign Country): Illinois
9a. FACILITY NAME (If not institution, give street and number): Montgomery General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Olney, Maryland		9c. COUNTY OF DEATH: Montgomery
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Brinklow		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 810 Brighton Knolls Drive		10f. ZIP CODE: 20862		10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): 3		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Pension Law Practitioner		16b. KIND OF BUSINESS/INDUSTRY: US. Government
17. FATHER'S NAME (First, Middle, Last): Mate Matijevic			18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Gasparac	
19a. INFORMANT'S NAME (Type/Print): Hildegard K. Matijevic		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 810 Brighton Knolls Drive Brinklow, Md. 20862		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Parklawn	DATE: 6/21	20c. LOCATION — City or Town, State: Rockville, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Philip D Rinaldi		22. NAME AND ADDRESS OF FACILITY: Hines/Rinaldi Funeral Home 11800 New Hampshire Ave. Silver Spring, Md.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	PULMONARY EMBOLI	Hours
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b.	BILATERAL DEEP VEIN THROMBOSIS	2 Days
DUE TO (OR AS A CONSEQUENCE OF): c.		
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	D25947	▶ JUNE 17, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
EVELYN JACKSON MD 5540 TWIN OAKS ROAD CHARLOTTESVILLE VA 22903

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 23 1995	Julia Davidson Randall

DHMH-18 Rev 1/89

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95 20101

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ida D. Myers		2. DATE OF DEATH (Month, Day, Year): June 13 1995	3. TIME OF DEATH: 8:00 A. M
4. SOCIAL SECURITY NUMBER: 578 62 0972	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 96 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): Jan. 2,1899
8. BIRTHPLACE (State or Foreign Country): Washington, D.C.			
9a. FACILITY NAME (If not institution, give street and number): Carriage Hill Nursing Centre	9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring	9c. COUNTY OF DEATH: Montgomery	

RESIDENCE OF DECEDENT

10a. STATE: N/A	10b. COUNTY: N/A	10c. CITY, TOWN OR LOCATION: Washington, D.C.	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1225 Girard Street, N.W.		10f. ZIP CODE: 20009	10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12):	College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher	16b. KIND OF BUSINESS/INDUSTRY: Public Schools
17. FATHER'S NAME (First, Middle, Last): Thomas Washington		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Washington	
19a. INFORMANT'S NAME (Type/Print): Alvin Gilbert Douglas, Jr.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3025 Ontario Road, N.W. Washington, D.C. 20009	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Baltimore Washington Crematory 6/16	20c. LOCATION — City or Town, State: Laurel, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: McGuire Funeral Service, Inc. 20012 7400 Georgia Ave. N.W., Washington, D.C.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Congestive Heart Failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Atherosclerotic Cardiovascular Disease.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hypothyroidism

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Jose F. Bonelli MD	29c. LICENSE NUMBER: D 35055	29d. DATE SIGNED (Month, Day, Year): 6/13/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOSE F. BONELLI, M.D. 8807 Colesville Road 5th Floor Silver Spring, Md. 20910		
31. DATE FILED (Month, Day, Year): JUN 21 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall	

DHMH-18 Rev 1/89

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95 20102

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEOENT'S NAME (First, Middle, Last): ROBERT A. MAZZOLINI SR			2. DATE OF DEATH (Month / Day / Year): 6 / 15 / 95	3. TIME OF DEATH: 8:37 A M
4. SOCIAL SECURITY NUMBER: 008-05-7548	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 77 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): March 28, 1918	8. BIRTHPLACE (State or Foreign Country): Vermont
9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring		9c. COUNTY OF DEATH: Montgomery
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Wheaton		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 11403 Sherrie Lane		10f. ZIP CODE: 20902		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS OECEDENT EVER IN U.S. ARMEO FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: WW II	13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12):	College (1-4 or 5+): 4	16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Accountant		16b. KIND OF BUSINESS/INDUSTRY: Savings & Loan Association
17. FATHER'S NAME (First, Middle, Last): Anthony Mazzolini			18. MOTHER'S NAME (First, Middle, Maiden Surname): Nina Bottinelli	
19a. INFORMANT'S NAME (Type/Print): Evangeline V. Mazzolini		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11403 Sherrie Land, Wheaton, MD 20902		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Neme of cemetery, cremetory or other place): Pleasant View Cemetery	DATE: 6/20/95	20c. LOCATION — City or Town, State: Randolph, VT	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Steven D Strand		22. NAME AND ADDRESS OF FACILITY: Francis J. Collins Funeral Home, Inc. 500 University Blvd.W. Sil.Spr.MD 20901		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not antar the moda of dying, such as cardiec or respiratory arrest, shock, or heart feilure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition resulting in death) →	a. PNEUMONIA	DAYS
Sequentially list conditions, if any, leading to immediete cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST	b. DUE TO (OR AS A CONSEQUENCE OF): COMATOSE STATE	WKS
	c. DUE TO (OR AS A CONSEQUENCE OF): END STAGE PARKINSON'S DISEASE	MOS. TO YRS.
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERREO TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF OEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF OEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. OATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. OESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Albert H. Stallman MD	29c. LICENSE NUMBER: D02404	29d. DATE SIGNED (Month, Day, Year) ▶ 6/15/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 1106 SPRING ST., SILVER SPRING MD. 20910.		
31. DATE FILED (Month, Day, Year): JUN 19 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall	

DHMH-16 Rev 1/89

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95 20103

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ESTHER MAE MILLER			2. DATE OF DEATH (Month, Day, Year): JUNE 17 1995	3. TIME OF DEATH: 8:55 AM
4. SOCIAL SECURITY NUMBER: 165-09-8749	5. SEX: 1 ☐ M 2 ☒ F	8. AGE (In yrs. last birthday): 84 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): June 19,1910	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): Suburban Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda		9c. COUNTY OF DEATH: Montgomery
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Bethesda		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 5716 Grosvenor Lane		10f. ZIP CODE: 20814		10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5 +): –	16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home		
17. FATHER'S NAME (First, Middle, Last): Martin Luther Fidler		18. MOTHER'S NAME (First, Middle, Meiden Surname): Annie Elizabeth Sholl		
19a. INFORMANT'S NAME (Type/Print): Willa Mae Loomis	19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code): 5716 Grosvenor Lane, Bethesda, Maryland 20814			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery DATE: June 20, 1995	20c. LOCATION — City or Town, State: Brentwood, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Richard D. Kuttler M00348	22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Ave., Bethesda, Maryland 20814			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory Failure	Immediate
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Sepsis	6 days
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Bipolar disorder
Diabetes

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☑ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street end Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end manner ee stated.
2 ☐ MEOICAL EXAMINER: On the beele of exemination end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(e) end manner ee stated.

29b. SIGNATURE ANO TITLE OF CERTIFIER: Richard Kuttler MD	29c. LICENSE NUMBER: D71435	29d. DATE SIGNEO (Month, Day, Year): ▶ June 17, 1995
30. NAME ANO ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print): Dr Paul Kuttler 7101 Medical Park Dr Silver Spring, MD 20902		
31. OATE FILED (Month, Day, Year): JUN 19 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall	

DHMH-18 Rev 1/89

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95 20104

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Daniel D. Musgrave			2. DATE OF DEATH (Month, Day, Year): June 16, 1995	3. TIME OF DEATH: 11:42 am M
4. SOCIAL SECURITY NUMBER: 053-03-9136	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): March 5, 1919	8. BIRTHPLACE (State or Foreign Country): New York
9a. FACILITY NAME (If not institution, give street and number): Suburban Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Cabin John	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 8201 Caraway Street		10f. ZIP CODE: 20818	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 8 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Consultant	16b. KIND OF BUSINESS/INDUSTRY: Self Employed	
17. FATHER'S NAME (First, Middle, Last): Charles B. Musgrave		18. MOTHER'S NAME (First, Middle, Maiden Surname): Agnes/ Not Available	
19a. INFORMANT'S NAME (Type/Print): Therese M. Musgrave		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8201 Caraway Street Cabin John, Maryland 20818	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Gate of Heaven Cemetery DATE: June 20, 1995	20c. LOCATION — City or Town, State: Silver Spring, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: George D Beshut M00335		22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Intracranial hemorrhage. DUE TO (OR AS A CONSEQUENCE OF):	15 hours.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [X]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: R. Steven Macedo, MD	29c. LICENSE NUMBER: D38530	29d. DATE SIGNED (Month, Day, Year): 6/16/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): R. Steven Macedo, MD 5530 Wisconsin Ave #1645 chevy

31. DATE FILED (Month, Day, Year): JUN 19 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

12+1

95 20105

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Khounsy Mala			2. DATE OF DEATH (Month, Day, Year): June 16, 1995	3. TIME OF DEATH: 4:44 P. M
4. SOCIAL SECURITY NUMBER: 579-04-4944	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 55 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Aug. 9, 1939	8. BIRTHPLACE (State or Foreign Country): Laos
9a. FACILITY NAME (If not institution, give street and number): Washington Adventist Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Takoma Park		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Silver Spring	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 609 Northampton Drive		10f. ZIP CODE: 20903	10g. CITIZEN OF WHAT COUNTRY?: Laos

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES:	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Asian

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Dishwasher	16b. KIND OF BUSINESS/INDUSTRY: Hospitality	
17. FATHER'S NAME (First, Middle, Last): Khamdy Mala		18. MOTHER'S NAME (First, Middle, Maiden Surname): Dui Seng	
19a. INFORMANT'S NAME (Type/Print): Bounsy Rajbandith	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7905-18th Ave., Hyattsville, MD 20783		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Chambers Crematory	DATE: 6/24	20c. LOCATION — City or Town, State: Riverdale, MD 20737
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: W.W. Chambers 6/20/95	22. NAME AND ADDRESS OF FACILITY: Chambers Funeral Home 5801 Cleveland Ave., Riverdale, MD 20737		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. BRONCHOGENIC CANCER OF LUNG	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. METASTASIN TO RIBS, ETC.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. POST OBSTRUCTIVE PNEUMONIA	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. COLLAPSE OF Lt LUNG. SECONDARY TO TUMOR OBSTRUCTION	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEHYDRATION
ANEMIA

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [X] NO [ ] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: (Physician)	29c. LICENSE NUMBER: D19935 MD	29d. DATE SIGNED (Month, Day, Year): 6/19/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 7610 CARROLLAVE # 320 TAKOMA PARK MD (S.L DESHAY, M.D.)		
31. DATE FILED (Month, Day, Year): JUN 20 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

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95 20106

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ruth McCoy Myers					2. DATE OF DEATH (Month, Day, Year): June 17, 1995	3. TIME OF DEATH: 12:30 P M
4. SOCIAL SECURITY NUMBER: 218-34-7455	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 81 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): July 4, 1913	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): 9610 Wire Avenue			9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring		9c. COUNTY OF DEATH: Montgomery	
RESIDENCE OF DECEDENT						
10a. STATE: Maryland	10b. COUNTY: Montgomery		10c. CITY, TOWN OR LOCATION: Silver Spring		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO	
10e. STREET AND NUMBER: 9610 Wire Avenue			10f. ZIP CODE: 20901		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5 +): 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary		16b. KIND OF BUSINESS/INDUSTRY: Federal Government	
17. FATHER'S NAME (First, Middle, Last): Samuel K. McCoy			18. MOTHER'S NAME (First, Middle, Maiden Surname): Florence Dengate			
19a. INFORMANT'S NAME (Type/Print): Robert J. Myers			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9610 Wire Ave., Silver Spring, MD 20901			
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan Crematory	DATE: 6/24/95	20c. LOCATION — City or Town, State: Alexandria, VA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Steven D Stroud			22. NAME AND ADDRESS OF FACILITY: Francis J. Collins Funeral Home, Inc. 500 University Blvd.W. Sil.Spr.MD 20901			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Chronic Renal Failure	10 Yrs.
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Hypertensive Cardiovascular Disease	20 Yrs.
DUE TO (OR AS A CONSEQUENCE OF):		
	c. Diabetes Mellitus	20 Yrs.
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)			
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
David G Luthringer	D 13771	▶ June 19, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): David G. Luthringer, M.D. 5530 Wisconsin Ave., Chevy Chase, MD 20015

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 20 1995	Julie Stevison Randall

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DHMH-16 Rev 1/89

95 20107

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William L. Moore					2. DATE OF DEATH (Month, Day, Year): June 19 1995	3. TIME OF DEATH: 0100 AM
4. SOCIAL SECURITY NUMBER: 216-12-4936	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 84 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Aug. 18, 1910	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Shady Grove Adventist Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Rockville		9c. COUNTY OF DEATH: MONTGOMERY	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Poolesville	10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: 19520 Jerusalem Church Terrace		10f. ZIP CODE: 20837	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6th; College (1-4 or 5 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Heavy Equipment Oper.	16b. KIND OF BUSINESS/INDUSTRY: Construction Co.	
17. FATHER'S NAME (First, Middle, Last): George H. Moore		18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie A. Owens	
19a. INFORMANT'S NAME (Type/Print): Cora E. Moore (Wife)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 19520 Jerusalem Ch. Ter., Poolesville, MD 20837		
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Jerusalem Church Cem.	DATE: 6/26	20c. LOCATION — City or Town, State: Poolesville, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: George L. Snowden	22. NAME AND ADDRESS OF FACILITY: SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. End Stage Renal Failure	4 years
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DIABETES Mellitus	20 years
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Subdural Hematoma

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO X UNCERTAIN ☐	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 X NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)			
27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D21340	29d. DATE SIGNED (Month, Day, Year): ▶ June 19, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RAYMOND BASS 3941 Ferrara Wheaton Md 20906		
31. DATE FILED (Month, Day, Year): JUN 22 1995	32. REGISTRAR'S SIGNATURE: [signature]	

DHMH-16 Rev 1/89

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95 20108

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): John George McWilliams				2. DATE OF DEATH (Month, Day, Year): June 25, 1995	3. TIME OF DEATH: 9:51 P M
4. SOCIAL SECURITY NUMBER: 577-24-3847	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 84 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Oct 15, 1910	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): St. Mary's Nursing Center			9b. CITY, TOWN OR LOCATION OF DEATH: Leonardtown		9c. COUNTY OF DEATH: St. Mary's

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: St. Mary's	10c. CITY, TOWN OR LOCATION: Coltons Point	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 5 Riverview Drive		10f. ZIP CODE: 20626	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Banker	16b. KIND OF BUSINESS/INDUSTRY: Bank	
17. FATHER'S NAME (First, Middle, Last): George McWilliams		18. MOTHER'S NAME (First, Middle, Maiden Surname): Claudia Grayson	
19a. INFORMANT'S NAME (Type/Print): John G. McWilliams, Jr.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3006 Lovelace Court, Waldorf, MD 20602	

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Sacred Heart Cemetery	DATE: 6/29/95	20c. LOCATION — City or Town, State: Bushwood, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Michael K Gardiner		22. NAME AND ADDRESS OF FACILITY: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pneumonia, Prob. Aspiration — DUE TO (OR AS A CONSEQUENCE OF):	5 days
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. — DUE TO (OR AS A CONSEQUENCE OF):	
	c. — DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Organic Brain Syndrome
Arteriosclerosis

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY — M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURED / 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D14285	29d. DATE SIGNED (Month, Day, Year): 6/26/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): William D. Boyd, II M.D. Leonardtown, Maryland 20650		
31. DATE FILED (Month, Day, Year): JUN 27 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

(6)

95 20109

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JAMES DANIEL MORGAN			2. DATE OF DEATH (Month, Day, Year): JUNE 15, 1995	3. TIME OF DEATH: 6:30 P M
4. SOCIAL SECURITY NUMBER: 579-12-3193	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 81 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Jan. 7, 1914
8. BIRTHPLACE (State or Foreign Country): Maryland				
9a. FACILITY NAME (If not institution, give street and number): St. Mary's Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Leonardtown	9c. COUNTY OF DEATH: St. Mary's		
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: St. Mary's	10c. CITY, TOWN OR LOCATION: Mechanicsville	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO	
10e. STREET AND NUMBER: P.O. Box 1106, James Rd.	10f. ZIP CODE: 20659	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.		
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR OATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th Grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Farmer	16b. KIND OF BUSINESS/INDUSTRY: Farm		
17. FATHER'S NAME (First, Middle, Last): John Woodley Morgan	18. MOTHER'S NAME (First, Middle, Maiden Surname): Myrtle Russell			
19a. INFORMANT'S NAME (Type/Print): Mary Louise Morgan	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 2 Box 1, Apt. #304, Leonardtown, Maryland 20650			
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Charles Memorial Gardens DATE 6/19/95	20c. LOCATION — City or Town, State: Leonardtown, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michael K. Gardiner	22. NAME AND ADDRESS OF FACILITY: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Aspiration	6/15/95
DUE TO (OR AS A CONSEQUENCE OF): b.	Aspiration Pneumonia & Cardiac Arrest	6/13/95
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	Stroke	12/94
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: History of Lung Cancer; History of Diabetes

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [✓] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [✓] NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be Determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: David M. Federle M.D.	29c. LICENSE NUMBER: D31785	29d. DATE SIGNED (Month, Day, Year): ▶ 6/16/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): David M. Federle, M.D. Leonardtown, Maryland 20650

31. DATE FILED (Month, Day, Year): JUN 19 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

95 20110

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Edwin Potter Marks			2. DATE OF DEATH (Month, Day, Year): June 8, 1995	3. TIME OF DEATH: 6:10 a. M
4. SOCIAL SECURITY NUMBER: 379-26-4680	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 70 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): April 22, 1925	8. BIRTHPLACE (State or Foreign Country): Michigan
9a. FACILITY NAME (If not institution, give street and number): P.O. Box 207		9b. CITY, TOWN OR LOCATION OF DEATH: Ridge		9c. COUNTY OF DEATH: St. Mary's
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: St. Mary's	10c. CITY, TOWN OR LOCATION: Ridge		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: P.O. Box 207		10f. ZIP CODE: 20680		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 8+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Research Entomologist		16b. KIND OF BUSINESS/INDUSTRY: U.S. Dept. of Agriculture
17. FATHER'S NAME (First, Middle, Last): Charles Barber Marks		18. MOTHER'S NAME (First, Middle, Maiden Surname): Edna Potter		
19a. INFORMANT'S NAME (Type/Print): Christiane Buchinger Marks		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 207, Ridge, Maryland 20680-0207		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan Crematory	DATE: 6-8-95	20c. LOCATION — City or Town, State: Alexandria, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Edward N. Brinsfield, Jr., M00052	22. NAME AND ADDRESS OF FACILITY: Brinsfield Funeral Home, P.A. 59 N. Washington St., Leonardtown, MD 20650-0279			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardiopulmonary Failure	hrs.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. DUE TO (OR AS A CONSEQUENCE OF):	Creutzfeldt-Jakob Disease	2-3 mo.
c. DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO N/A

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: J. Patrick Jarboe, M.D. | 29c. LICENSE NUMBER: D06419 | 29d. DATE SIGNED (Month, Day, Year): ▶ 6-8-95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): J. Patrick Jarboe, M.D., Medical Arts Building, Leonardtown, Maryland 20650

31. DATE FILED (Month, Day, Year): JUN - 9 1995 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

95 20111

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
EVELYN	ELIZABETH	MORELAND	JUNE 06 1995	11.25 A.M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
213-40-8290	1 ☐ M 2 ☒ F	59 YRS.			January 7, 1936	Cedarville, MD

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
St. Mary's Hospital	Leonardtown	St. Mary's

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	St. Mary's	Mechanicsville	1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
3190 Flora Corner Road	20659	United States

11. MARITAL STATUS	12. WAS DECEOENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12	- - - -	Personnel Assistant	U.S. Commerce Department

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
William M. Proctor	Gussie M. Smallwood

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Janice Williams	3190 Flora corner Road, Mechanicsville, MD 20659

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Queen of Peace	6/10/95	Helen, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
Edward N. Brinsfield, Jr. M00052	Brinsfield Funeral Home P.O. Box 279, Leonardtown, Maryland 20650

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Sepsis (Fungal) DUE TO (OR AS A CONSEQUENCE OF):	6/1/95
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b.	fungal Urinary Tract Infection DUE TO (OR AS A CONSEQUENCE OF):	UNKNOWN
c.	DUE TO (OR AS A CONSEQUENCE OF):	
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Severe Oxygen Brain Syndrome
Pulmonary Edema
End Stage Renal Disease Hypertension Heart Disease

DID TOBACCO USE CONTRIBUTE TO DEATH? YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined			1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
David M. Federle MD	D37178	▶ 6/7/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	
David M. Federle, M.D.	600 Moakley Street, Leonardtown, Maryland 20650

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN - 9 1995	Julia Thurston-Randall

DHMH-16 Rev 1/89

95 20112

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Robert Calvin Maus			2. DATE OF DEATH (Month, Day, Year): May 30, 1995	3. TIME OF DEATH: 9:20 P. M
4. SOCIAL SECURITY NUMBER: 176-05-1597	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): August 10, 1916	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): 107 Harbor Lane, Town Creek		9b. CITY, TOWN OR LOCATION OF DEATH: Lexington Park		9c. COUNTY OF DEATH: St. Mary's

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: St. Mary's	10c. CITY, TOWN OR LOCATION: Lexington Park	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 107 Harbor Lane, Town Creek		10f. ZIP CODE: 20653	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): - - - -	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Supervisor of Engineering	16b. KIND OF BUSINESS/INDUSTRY: U.S. Navy/Defense	
17. FATHER'S NAME (First, Middle, Last): Paul Homer G. Maus		18. MOTHER'S NAME (First, Middle, Maiden Surname): Lula Mae Chronister	
19a. INFORMANT'S NAME (Type/Print): Estie E. Maus	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 107 Harbor Lane, Town Creek, Lexington Park, MD 20653		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): St. Peter Lescney's DATE: 6/3/95	20c. LOCATION — City or Town, State: Spring Grove, Pennsylvania	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Edward N. Brinsfield, Jr. M00052	22. NAME AND ADDRESS OF FACILITY: Brinsfield Funeral Home, P.O. Box 279, Leonardtown, Maryland 20650		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CARDIOMYOPATHY.	4 yrs
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. CONGESTIVE Heart failure	4 yrs
DUE TO (OR AS A CONSEQUENCE OF):		
	c. Hypertension.	20 yrs
DUE TO (OR AS A CONSEQUENCE OF):		
	d. DIABETES MELLITUS.	84 yrs

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic Renal failure

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): N/A	28b. TIME OF INJURY: M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED: N/A	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D23634	29d. DATE SIGNED (Month, Day, Year): ▶ 5/31/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Adinath A. Patil, M.D. Shanti Medical Center, Leonardtown, Maryland 20650

31. DATE FILED (Month, Day, Year): JUN -1 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

N/A

DOT

95 20113

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BB Mc Crae Devaughn Clifton Murdock

2. DATE OF DEATH (Month, Day, Year): 06 - 09 - 95

3. TIME OF DEATH: 9:15 AM

4. SOCIAL SECURITY NUMBER:

5. SEX: 1 ☐ M 2 ☐ F — 1

6. AGE (In yrs. last birthday): YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. 30

7. DATE OF BIRTH (Month, Day, Year): 06/09/95

8. BIRTHPLACE (State or Foreign Country): Prince Georgs

9a. FACILITY NAME (If not Institution, give street and number): Prince Georges Hospital Center

9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly, Md

9c. COUNTY OF DEATH: PG

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Prince Georgds

10c. CITY, TOWN OR LOCATION: Seabrook

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 7204 Goodluck Road

10f. ZIP CODE: 20706

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 0
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): none

16b. KIND OF BUSINESS/INDUSTRY: none

17. FATHER'S NAME (First, Middle, Last): Joseph Clifton Murdock

18. MOTHER'S NAME (First, Middle, Maiden Surname): Michelle Antionette Mccrae

19a. INFORMANT'S NAME (Type/Print): Mother

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7204 Goodluck Road, Seabrook, Maryland 20706

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) by hosp

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) — DATE

20c. LOCATION — City or Town, State

21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶

22. NAME AND ADDRESS OF FACILITY

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Respiratory failure
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Immaturity (21 weeks gestation)
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D.

29c. LICENSE NUMBER: D27628

29d. DATE SIGNED (Month, Day, Year) ▶ 6-9-95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Isabelita G. Fraginola MD

31. DATE FILED (Month, Day, Year): JUL 06 1995

32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

95 20114

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
JANET	LUCILE	NAUMBURG	JUNE 20, 1995	11:36 P.M.

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
105-36-0823	1 ☐ M 2 ☒ F	45 YRS.			APRIL 22, 1950	NEW YORK

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
9103 WOODLAND DRIVE	SILVER SPRING	MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MARYLAND	MONTGOMERY	SILVER SPRING	1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
9103 WOODLAND DRIVE	20910	UNITED STATES

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
	5+	HOMEMAKER	OWN HOME

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
GEORGE WASHINGTON NAUMBURG JR.	DELIA HEMING

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MICHAEL GRAVITZ (HUSBAND)	9103 WOODLAND DRIVE - SILVER SPRING, MD. 20910

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	MT. COMFORT CREMATORY	6/23	ALEXANDRIA, VIRGINIA

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
Frank A. Stone	DANANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE - ROCKVILLE, MD. 20852

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. METASTATIC AND LOCALLY RECURRENT BREAST CANCER	5 YEARS AND 7 MONTHS
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	28. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	26a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY	26c. INJURY AT WORK?	26d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Christopher Hendricks MD	D37236	▶ JUNE 21, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
9707 Medical Center Dr. Suite 300, Rockville, MD 20850

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 23 1995	Julia Theodosar Randall

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OHMH-16 Rev 1/89

95 20115

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ERNST W. NEUMANN			2. DATE OF DEATH (Month, Day, Year): June 18, 1995	3. TIME OF DEATH: 12:01 A M
4. SOCIAL SECURITY NUMBER: 577-52-2612	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 75 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Feb.23,1920	8. BIRTHPLACE (State or Foreign Country): Germany
9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Silver Spring	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 11609 Maple View Drive		10f. ZIP CODE: 20902	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Consultant Engineer	16b. KIND OF BUSINESS/INDUSTRY: NASA
17. FATHER'S NAME (First, Middle, Last): Karl Neumann		18. MOTHER'S NAME (First, Middle, Maiden Surname): Berta Winhnewski	
19a. INFORMANT'S NAME (Type/Print): Hannelore R. Neumann		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11609 Maple View Drive Silver Spring, Maryland 20902	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan Crematory DATE: 06/18/95	20c. LOCATION — City or Town, State: Alexandria, Virginia
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Martha Pickell		22. NAME AND ADDRESS OF FACILITY: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil.Spr., MD 20901	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Respiratory Failure	2d
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Pneumonia	2d
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Acute Myelogenous Leukemia	4 mo
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Pancytopenia

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [X]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Peter B. Sherer MD	29c. LICENSE NUMBER: D21910	29d. DATE SIGNED (Month, Day, Year): 6/18/95 (one signature missing)
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Peter B. Sherer MD 3947 Ferrara Dr. Wheaton, MD 20906		
31. DATE FILED (Month, Day, Year): JUN 21 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

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95 20116

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
Charles	B.	Nichols	June 19, 1995	11:55 P M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
213-01-8743	1 [X] M 2 [ ] F	83 YRS.			Feb. 16, 1912	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Suburban Hospital	Bethesda	Montgomery

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Montgomery	Bethesda	1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
4609 Cheltenham Drive	20814	United States

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] YES 2 [X] NO	1 [ ] YES 2 [X] NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
10	-	Manager	Safeway

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Clinton Nichols	Della Cosgrove

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mabel E. Nichols	4609 Cheltenham Drive, Bethesda, Maryland 20814

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
[X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Parklawn Memorial Park	June 22, 1995	Rockville, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FACILITY
▶ Michele P. Kutta	M00348	Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Ave., Bethesda, Maryland 20814

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Anemia	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Gastrointestinal Hemorrhage	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Parkinson's Disease

Pneumonia

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [ ] YES 2 [X] NO	HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined		M	1 [ ] YES 2 [ ] NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Brent A. Berger MD	D37840	▶ June 20, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Brent A. Berger, M.D. 11125 Rockville Pike #103, Rockville, MD 20852

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 21 1995	Julia Davidson-Corbett

DHMH-16 Rev 1/89

8

95 20117

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JENNIE WILHELMINA NICHOLAS			2. DATE OF DEATH (Month, Day, Year): JUNE 22, 1995	3. TIME OF DEATH: 7: 23 pm M
4. SOCIAL SECURITY NUMBER: 082-20-8170	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 78 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): May 3, 1917	8. BIRTHPLACE (State or Foreign Country): New York
9a. FACILITY NAME (If not institution, give street and number): Washington Adventist Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Takoma Park		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: St. Mary's	10c. CITY, TOWN OR LOCATION: California	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1032 Rosewood		10f. ZIP CODE: 20619	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade — College (1-4 or 5+): 5 years	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher	16b. KIND OF BUSINESS/INDUSTRY: Public School	
17. FATHER'S NAME (First, Middle, Last): Frans Hilmer Salminen		18. MOTHER'S NAME (First, Middle, Maiden Surname): Olga Maria Wainio	
19a. INFORMANT'S NAME (Type/Print): William F. Nicholas		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 2 Box 388, Hollywood, Maryland 20636	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): St. John's Cemetery — DATE: 6/26/1995	20c. LOCATION — City or Town, State: Hollywood, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Michael F. Gardiner		22. NAME AND ADDRESS OF FACILITY: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. PULMONARY EDEMA	96 Hrs.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. AORTIC STENOSIS	1 Yr
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. PROSMETIC MITRAL VALVE	1984
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. GASTROINTESTINAL BLEED	2 mos.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
RENAL FAILURE ANEMIA PULMONARY
VANCOMYCIN RESISTANT ENTEROCOCCUS - HYPERTENSION

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Oles B. Bartoszyk	29c. LICENSE NUMBER: D39909	29d. DATE SIGNED (Month, Day, Year): 6-23-95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): OLES B. BARTOSZYK 7501 SURRATTS RD SUITE 307 CLINTON MD 20735		
31. DATE FILED (Month, Day, Year): JUN 27 1995	32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall	

(12)

OHMH-16 Rev 1/89

95 20118

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Benjamin Franklin Owens, Jr.		2. DATE OF DEATH (Month, Day, Year): May 29, 1995	3. TIME OF DEATH: 12:15 a. M
4. SOCIAL SECURITY NUMBER: 216-22-3469	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 66 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Feb. 23, 1929 — 8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Bayside Nursing Center		9b. CITY, TOWN OR LOCATION OF DEATH: Lexington Park	9c. COUNTY OF DEATH: St. Mary's
RESIDENCE OF DECEDENT			
10a. STATE: Maryland	10b. COUNTY: St. Mary's	10c. CITY, TOWN OR LOCATION: Piney Point	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: P.O. Box 301		10f. ZIP CODE: 20692	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Route Salesman	16b. KIND OF BUSINESS/INDUSTRY: Confectionery Industry	
17. FATHER'S NAME (First, Middle, Last): Benjamin Franklin Owens, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Frances Wilkinson	
19a. INFORMANT'S NAME (Type/Print): Carolyn L. Nelson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 440 Marion Dr., Mechanicsville, Maryland 20659	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place): Metropolitan Crematory — DATE	20c. LOCATION — City or Town, State: Alexandria, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Michael L Gardiner		22. NAME AND ADDRESS OF FACILITY: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Carcinoma of Left lung → NOV 1994
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Status post trachestomy
Pneumonia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) — 28b. TIME OF INJURY M — 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO — 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: KMcK — 29c. LICENSE NUMBER: D36206 — 29d. DATE SIGNED (Month, Day, Year): ▶ 05/30/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Kiran D. Mehta Leonardtown MD 20650

31. DATE FILED (Month, Day, Year): JUN - 2 1995 — 32. REGISTRAR'S SIGNATURE: Julia Dawson-Randall

DHMH-16 Rev 1/89

95 20119

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): TYLER James PRICE			2. DATE OF DEATH (Month, Day, Year): JUNE 24, 1995	3. TIME OF DEATH: 22:30 PM
4. SOCIAL SECURITY NUMBER: 218-43-2368	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): YRS.	IF UNDER 1 YEAR: MONTHS 3 DAYS 20; IF UNDER 24 HRS.: HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year): March 4, 1995
8. BIRTHPLACE (State or Foreign Country): Maryland				
9a. FACILITY NAME (If not Institution, give street and number): THE JOHNS HOPKINS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH: ---

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Parkton	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 2324 Traceys Store Road		10f. ZIP CODE: 21120	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): None	16b. KIND OF BUSINESS/INDUSTRY: None	
17. FATHER'S NAME (First, Middle, Last): James L. Price		18. MOTHER'S NAME (First, Middle, Maiden Surname): Kimberly I. Isennock	
19a. INFORMANT'S NAME (Type/Print): James L. Price	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2324 Traceys Store RD., Parkton, Md. 21120		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Middletown Cemetery DATE: 6/28/95	20c. LOCATION — City or Town, State: Freeland, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: J.J. Hartenstein	22. NAME AND ADDRESS OF FACILITY: J.J.Hartenstein Mortuary 24 Second St., New Freedom, Pa.17349		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Aspiration	15 Minutes
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST. DUE TO (OR AS A CONSEQUENCE OF): b.	Dysfunctional swallow	life long
DUE TO (OR AS A CONSEQUENCE OF): c.	Gastric Paresis	life long
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypotonia, chronic lung disease, hyperbilirubinemia, Double outlet right ventricle

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Donald N Shatner Jr	29c. LICENSE NUMBER: 27546	29d. DATE SIGNED (Month, Day, Year): 6/24/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Donald N Shatner Jr Halsted 842E JHH

31. DATE FILED (Month, Day, Year): JUL 03 1995	32. REGISTRAR'S SIGNATURE: Julia Strachan-Randall

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 Rev 1/89

95 20120

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JAMES ALTON POWELL			2. DATE OF DEATH (Month, Day, Year): June 26 1995	3. TIME OF DEATH: 0133 AM
4. SOCIAL SECURITY NUMBER: 213-24-8842	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 65 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): JUNE 26, 1930	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): WASHINGTON COUNTY HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: HAGERSTOWN		9c. COUNTY OF DEATH: WASHINGTON

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: WASHINGTON	10c. CITY, TOWN OR LOCATION: HAGERSTOWN	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1004-A NOLAND DRIVE		10f. ZIP CODE: 21740	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. OECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): BARBER	16b. KIND OF BUSINESS/INDUSTRY: BARBER SHOP	
17. FATHER'S NAME (First, Middle, Last): JAMES GROVE POWELL		18. MOTHER'S NAME (First, Middle, Maiden Surname): GRACE IRENE BRIGHTWELL	
19a. INFORMANT'S NAME (Type/Print): BETTY J. MAGAHA		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1004-A NOLAND DRIVE, HAGERSTOWN, MD. 21740	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): CEDAR LAWN MEMORIAL PARK DATE 06-28-95	20c. LOCATION — City or Town, State: HAGERSTOWN, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: R. Noel Brady		22. NAME AND ADDRESS OF FACILITY: ANDREW K. COFFMAN FUNERAL HOME, INC. 40 E. ANTIETAM ST., HAGERSTOWN, MD. 21740	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Congestive Heart Failure	3 months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Dilated cardiomyopathy	2 YEARS
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Coronary artery disease	5 YEARS
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hyponatremia
Atrial fibrillation

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [✓]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD		29c. LICENSE NUMBER: D44996	29d. DATE SIGNED (Month, Day, Year): June 26, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ZAFAR MALIK MD 20311 LAPPONS RD BOONSBORO MD 21713.			
31. DATE FILED (Month, Day, Year): JUN 29 1995	32. REGISTRAR'S SIGNATURE: [signature]		

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 20121

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
BARBARA	SUSAN	PINARDI	JUNE 21, 1995	0025 A M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
196-38-5342	1 ☐ M 2 ☒ F	46 YRS.			MAY 24, 1949	PENNSYLVANIA

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
SACRED HEART HOSPITAL	CUMBERLAND	ALLEGANY

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MARYLAND	ALLEGANY	CUMBERLAND	1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
322 SUNSET DRIVE	21502	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)	SECRETARY	MEDICAL EQUIPMENT/SUPPLY
	2		

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
AVARDO G. RAMICONE	ELIZABETH SCHUETZ

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ANTHONY A. PINARDI	322 SUNSET DRIVE-CUMBERLAND, MD 21502

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	SS. PETER & PAUL CEM.	6/24/95	CUMBERLAND, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Wendy D. Upchurch	GEORGE-UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Breast Cancer.	14 months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Adeno carcinoma of the Breast	17 years
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	OUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Bone and Lung Metastasis

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
MD FACP	D13601	▶ JUNE 21 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
V. RAUL FELIPA 925 Bishop Walsh Rd Cumberland Md 21502

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 23 1995	Gilda Gardner-Randall

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DHMH-16 Rev 1/89

95 20122

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): FRANCIS EDWARD PRINTY		2. DATE OF DEATH (Month, Day, Year): Jun 13, 1995	3. TIME OF DEATH: 12:20 A M
4. SOCIAL SECURITY NUMBER: 217-30-1470	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 60 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Apr 11, 1935
8. BIRTHPLACE (State or Foreign Country): MD			
9a. FACILITY NAME (If not institution, give street and number): ROUTE 2 BOX 74	9b. CITY, TOWN OR LOCATION OF DEATH: OLDTOWN	9c. COUNTY OF DEATH: ALLEGANY	
RESIDENCE OF DECEDENT			
10a. STATE: MD	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Oldtown	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: Route 2 Box 74	10f. ZIP CODE: 21555	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: Korean	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Self-employed	16b. KIND OF BUSINESS/INDUSTRY: Masonry	
17. FATHER'S NAME (First, Middle, Last): Virgil Printy	18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine (Orndorff)		
19a. INFORMANT'S NAME (Type/Print): Margaret D. Printy	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Route 2 Box 74; Oldtown, MD 21555		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Restlawn Memorial Gardens DATE: 06/16	20c. LOCATION — City or Town, State: LaVale, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James F. Scarpelli	22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home Cumberland, MD 21502		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Carcinoma lung, metastatic	6 months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Emphysema
Arteriosclerosis

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [X] NO [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] MD	D 12532	June 13, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. George Breza 912 Seton Drive; Cumberland, MD 21502

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 14 1995	[signature]

DHMH-16 Rev 1/89

95 20123

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Albert Perin			2. DATE OF DEATH (Month, Day, Year): JUNE 18, 1995	3. TIME OF DEATH: 6:30 AM
4. SOCIAL SECURITY NUMBER: 092-02-6273	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 77 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): AUG. 6, 1917	8. BIRTHPLACE (State or Foreign Country): NEW YORK
9a. FACILITY NAME (If not institution, give street and number): HEBREW HOME OF GREATER WASHINGTON		9b. CITY, TOWN OR LOCATION OF DEATH: ROCKVILLE		9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: GAITHERSBURG	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 18913 MILLS CHOICE ROAD #3		10f. ZIP CODE: 20879	10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WW II	13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): OWNER	16b. KIND OF BUSINESS/INDUSTRY: VARIETY STORE	
17. FATHER'S NAME (First, Middle, Last): LOUIS PERIN		18. MOTHER'S NAME (First, Middle, Maiden Surname): MINNIE LANDSMAN	
19a. INFORMANT'S NAME (Type/Print): GERALDINE LORD (DAUGHTER)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 19813 SHADY BROOK WAY - GAITHERSBURG, MARYLAND 20879	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place): MT. COMFORT CREMATORY	DATE: 6/21	20c. LOCATION — City or Town, State: ALEXANDRIA, VIRGINIA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert B. Kinnamon	22. NAME AND ADDRESS OF FACILITY: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE - ROCKVILLE, MD. 20852		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory Failure	1 week
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Chronic Obstructive Pulmonary Disease	long-standing
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.: Congestive Heart Failure

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [✓]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [✓] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Ira Paul Kleiger MD	29c. LICENSE NUMBER: D21435	29d. DATE SIGNED (Month, Day, Year): June 18, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ira Paul Kleiger 2101 Medical Park Dr Silver Spring Md 20902		
31. DATE FILED (Month, Day, Year): JUN 23 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall	

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DHMH-16 Rev 1/89

95 20124

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Doris Schepp Pittore				2. DATE OF DEATH (Month, Day, Year): June 14 1995	3. TIME OF DEATH: 02:15 AM
4. SOCIAL SECURITY NUMBER: 055-10-0763	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 79 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Nov. 30, 1915	8. BIRTHPLACE (State or Foreign Country): New York
9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH: N/A

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Howard	10c. CITY, TOWN OR LOCATION: Ellicott City		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 8026 Nottingham Way		10f. ZIP CODE: 21043		10g. CITIZEN OF WHAT COUNTRY? United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 1	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY: Own Home

17. FATHER'S NAME (First, Middle, Last): Joseph Schepp	18. MOTHER'S NAME (First, Middle, Maiden Surname): ELizabeth Schulthis
19a. INFORMANT'S NAME (Type/Print): Jane Herbert	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7782 Heatherton Lane, Potomac, MD 20854

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE: Metropolitan Crematory 6/15/95	20c. LOCATION — City or Town, State: Alexandria, VA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Michael D. Gibbons	22. NAME AND ADDRESS OF FACILITY: DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. HEART FAILURE
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. MYOCARDIAL INFARCTION
DUE TO (OR AS A CONSEQUENCE OF):
c. ATHEROSCLEROSIS
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
BACTERIAL PNEUMONIA, COPD
PERIPHERAL VASCULAR DZ

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☒ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD	29c. LICENSE NUMBER: D40012	29d. DATE SIGNED (Month, Day, Year): JUNE 14, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Scott Poulton, 4600 Wilkens Ave, Suite 107, Baltimore, MD 21229

31. DATE FILED (Month, Day, Year): JUN 21 1995	32. REGISTRAR'S SIGNATURE: Julia Hudson Randall

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95 20125

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Amely Petrossian			2. DATE OF DEATH (Month, Day, Year): June 17 1995	3. TIME OF DEATH: 11:55 a M
4. SOCIAL SECURITY NUMBER: 218-08-4975	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 66 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Dec. 28, 1928	8. BIRTHPLACE (State or Foreign Country): Iran
9a. FACILITY NAME (If not institution, give street and number): 19041 Stedwick Drive		9b. CITY, TOWN OR LOCATION OF DEATH: Gaithersburg	9c. COUNTY OF DEATH: Montgomery	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Gaithersburg	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 19041 Stedwick Drive	10f. ZIP CODE: 20879	10g. CITIZEN OF WHAT COUNTRY?: United States	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Iranian

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Levon Levonionpour	16. MOTHER'S NAME (First, Middle, Maiden Surname): Sanam Ghazarian		
19a. INFORMANT'S NAME (Type/Print): Miran Petrossian	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 19041 Stedwick Drive, Gaithersburg, MD 20879		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Gate of Heaven Cemetery DATE 6/20/95	20c. LOCATION — City or Town, State: Silver Spring, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]	22. NAME AND ADDRESS OF FACILITY: DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Liver Cancer	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Pelvic Mass	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D 03716	29d. DATE SIGNED (Month, Day, Year) ▶ June 19, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Tibor E. Frekko, MD, 19211 Montgomery Village, Gaithersburg, MD 20879

31. DATE FILED (Month, Day, Year): JUN 21 1995	32. REGISTRAR'S SIGNATURE: [signature]

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95 20126

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Jean S. Ploski				2. DATE OF DEATH (Month, Day, Year): June 16 1995		3. TIME OF DEATH: 8:45 A M
4. SOCIAL SECURITY NUMBER: 045-26-1748	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 60 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): July 9, 1934	8. BIRTHPLACE (State or Foreign Country): Connecticut
9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring		9c. COUNTY OF DEATH: Montgomery	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Rockville	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 4409 Bel Pre Road		10f. ZIP CODE: 20853	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Title Clerk	16b. KIND OF BUSINESS/INDUSTRY: State Government	
17. FATHER'S NAME (First, Middle, Last): James Negri		18. MOTHER'S NAME (First, Middle, Maiden Surname): Loretta Montgomery	
19a. INFORMANT'S NAME (Type/Print): Thomas B. Ploski		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4409 Bel Pre Road Rockville, Maryland 20853	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Gate of Heaven Cemetery DATE: 6/21/95	20c. LOCATION — City or Town, State: Silver Spring, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert E. Ramsey		22. NAME AND ADDRESS OF FACILITY: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. METASTATIC Lung Cancer	3 yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Respiratory failure

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☒ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D29675	29d. DATE SIGNED (Month, Day, Year): ▶ 6/18/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RAPHAEL V. BOCCIA, MD 9707 MEDICAL CTR Dr Rockville		
31. DATE FILED (Month, Day, Year): JUN 21 1995	32. REGISTRAR'S SIGNATURE: Julia Dawkins-Randall	

DHMH-16 Rev 1/89

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95-3590-027

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95 20127

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN D. POTTER				2. DATE OF DEATH (Month, Day, Year): JUNE 19 1995	3. TIME OF DEATH: 7:15 PM
4. SOCIAL SECURITY NUMBER: 286-74-6368	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 31 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): June 28,1963	8. BIRTHPLACE (State or Foreign Country): Ohio
9a. FACILITY NAME (If not institution, give street and number): MARYLAND RTE# 29 NORTH BOUND			9b. CITY, TOWN OR LOCATION OF DEATH:		9c. COUNTY OF DEATH: HOWARD	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Silver Spring	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 15 Windmill Court		10f. ZIP CODE: 20905	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: 1981-1985	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Police Officer	16b. KIND OF BUSINESS/INDUSTRY: Maryland Nat.Capital Park Poli	
17. FATHER'S NAME (First, Middle, Last): Jerry A. Potter		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ruth Ann Betz	
19a. INFORMANT'S NAME (Type/Print): Laurie Potter	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15 Windmill Court Silver Spring, Md 20905		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Arlington National Cem DATE 6/26/95	20c. LOCATION — City or Town, State: Arlington, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Shelly D Rinaldi	22. NAME AND ADDRESS OF FACILITY: HINES-RINALDI FUNERAL HOME 11800 New Hampshire Ave Silver Spring, Md		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Multiple Injuries.	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [XX] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) SCENE		
27. MANNER OF DEATH: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 6-19-95	28b. TIME OF INJURY: 1910 M	28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO
	28d. DESCRIBE HOW INJURY OCCURED: Driver motorcycle fell 30' fixed object		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Roadway	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Rt 29	

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: O.C.M.E	29d. DATE SIGNED (Month, Day, Year): ▶ JUNE 20,1995
30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201		
31. DATE FILED (Month, Day, Year): JUN 22 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

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95 20128

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): George Thomas Purcell
2. DATE OF DEATH (Month, Day, Year): June 27, 1995
3. TIME OF DEATH: 2:50 AM
4. SOCIAL SECURITY NUMBER: 219-16-2407
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 89 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)
7. DATE OF BIRTH (Month, Day, Year): Jul 2, 1905
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Bayside Nursing Home
9b. CITY, TOWN OR LOCATION OF DEATH: Lexington Park
9c. COUNTY OF DEATH: St. Mary's

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: St. Mary's
10c. CITY, TOWN OR LOCATION: Drayden
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Box 83, Windmill Point
10f. ZIP CODE: 20630
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th Grade; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Farmer
16b. KIND OF BUSINESS/INDUSTRY: Farm
17. FATHER'S NAME (First, Middle, Last): Charles Fulton Purcell
18. MOTHER'S NAME (First, Middle, Maiden Surname): Flora Priscilla McKay
19a. INFORMANT'S NAME (Type/Print): Lillian Marie Purcell
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Box 83 Windmill Point, Drayden, MD 20630
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): St. George cath Cemetery — DATE:
20c. LOCATION — City or Town, State: Valley Lee, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Michael K Gardiner
22. NAME AND ADDRESS OF FACILITY: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardiopulmonary Failure	hrs.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b.	Cardiomyopathy	2 yrs
DUE TO (OR AS A CONSEQUENCE OF): c.	Coronary Artery Disease	years
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: None

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO N.A.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
26a. DATE OF INJURY (Month, Day, Year)
26b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
26a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: J. Patrick Jarboe M.D.
29c. LICENSE NUMBER: D0649
29d. DATE SIGNED (Month, Day, Year): 6-26-95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. Patrick Jarboe, M.D. Leonardtown, Maryland 20650
31. DATE FILED (Month, Day, Year): JUN 29 1995
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RKD
95-3634-025

95 20129

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HOPE LACREATIA RIVERA				2. DATE OF DEATH (Month, Day, Year): JUNE 21 95	3. TIME OF DEATH: 9:10 AM
4. SOCIAL SECURITY NUMBER: N/A	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): YRS.	IF UNDER 1 YEAR: MONTHS 2 DAYS 21 / IF UNDER 24 HRS.: HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year): Mar.31,1995	8. BIRTHPLACE (State or Foreign Country): Lancaster,PA
9a. FACILITY NAME (If not institution, give street and number): FALLSTON GENERAL HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: FALLSTON		9c. COUNTY OF DEATH: HARFORD COUNTY

RESIDENCE OF DECEDENT

10a. STATE: PA	10b. COUNTY: Lancaster	10c. CITY, TOWN OR LOCATION: Lancaster	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 339 W. Grant St.		10f. ZIP CODE: 17603	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☒ YES 2 ☐ NO Specify: Puerto Rican	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0 / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): N/A	16b. KIND OF BUSINESS/INDUSTRY: N/A	
17. FATHER'S NAME (First, Middle, Last): William J. Rivera		18. MOTHER'S NAME (First, Middle, Maiden Surname): Thomasinda Seymour	
19a. INFORMANT'S NAME (Type/Print): Thomasinda Seymour	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 339 W. Grant St.,Lancaster, PA 17603		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place): Mellinger's Mennonite Cem.	DATE: 6/26/95	20c. LOCATION — City or Town, State: E.Lampeter Twp.,PA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John B. Thomas 0048	22. NAME AND ADDRESS OF FACILITY: Fred F. Groff,Inc. 234 W. Orange St.,Lancaster,PA 17603		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Sudden Infant Death Syndrome	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Dennis J. Cluck MD	29c. LICENSE NUMBER: O.C.M.E.	29d. DATE SIGNED (Month, Day, Year): JUNE 22,1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 111 Penn Street, Baltimore, Maryland 21201		
31. DATE FILED (Month, Day, Year): JUL 03 1995	32. REGISTRAR'S SIGNATURE: John Wheeler-Bartlett	

DHMH-16 Rev 1/89

95 20130

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mary Etta REID		2. DATE OF DEATH (Month, Day, Year): June 22 1995	3. TIME OF DEATH: 11:35 AM
4. SOCIAL SECURITY NUMBER: 214-09-5703	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 86 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Jan. 17 1909
8. BIRTHPLACE (State or Foreign Country): Maryland			
9a. FACILITY NAME (If not institution, give street and number): Washington County Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown	9c. COUNTY OF DEATH: Washington	
RESIDENCE OF DECEDENT			
10a. STATE: Maryland	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Funkstown	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 119 West Side Street	10f. ZIP CODE: 21734	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Her own home	
17. FATHER'S NAME (First, Middle, Last): Wilber Stauffer	18. MOTHER'S NAME (First, Middle, Maiden Surname): Blanche Sheppard		
19a. INFORMANT'S NAME (Type/Print): Jacob L. Reid	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 119 West Side Street Funkstown, Md. 21734		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, cremetory or other place): Rose Hill Cemetery DATE 6/24/95	20c. LOCATION — City or Town, State: Hagerstown, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert A. Haines	22. NAME AND ADDRESS OF FACILITY: Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Aspiration Pneumonia	3 DAYS
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Cerebro-vascular accident	1 DAY
DUE TO (OR AS A CONSEQUENCE OF):		
	c. Renal Failure	2 DAYS
DUE TO (OR AS A CONSEQUENCE OF):		
	d. Severe Dehydration.	1 week

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Breast Carcinoma
Organic Brain Syndrome

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
MD	D44996	▶ June 22, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ZAFAR MALIK 20311 CAPPANS RD BOONSBORO MD 21713

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 23 1995	

DHMH-16 Rev 1/89

95 20131

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Lorraine L. ROWE	2. DATE OF DEATH Month: June Day: 24 Year: 1995	3. TIME OF DEATH: 1234 PM	
4. SOCIAL SECURITY NUMBER: 218-24- 7776	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 66 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): April 29,1929
8. BIRTHPLACE (State or Foreign Country): Hagerstown,Md.			
9a. FACILITY NAME (If not institution, give street and number): Washington County Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown	9c. COUNTY OF DEATH: Washington	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Sharpsburg	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 207 W. Chapline St.	10f. ZIP CODE: 21782	10g. CITIZEN OF WHAT COUNTRY?: U. S. A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9 — College (1-4 or 5 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Walter P. Speaker	18. MOTHER'S NAME (First, Middle, Maiden Surname): Geralein Mose		
19a. INFORMANT'S NAME (Type/Print): Homer E. Rowe	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 207 W. Chapline St. Sharpsburg, Md. 21782		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Mountain View Cemetery DATE: 6-27-95	20c. LOCATION — City or Town, State: Sharpsburg, Md. 21782	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John H. Bast, Jr.	22. NAME AND ADDRESS OF FACILITY: BAST FUNERAL HOME, 7606 Old National Pike Boonsboro, Md. 21713		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	ANOXIC BRAIN INJURY	3 DAYS
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	CARDIOGENIC SHOCK	3 DAYS
DUE TO (OR AS A CONSEQUENCE OF):		
c.	MYOCARDIAL INFARCTION	3 DAYS
DUE TO (OR AS A CONSEQUENCE OF):		
d.	CARDIAC ARRYHTHMIAS	3 DAYS

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

DIABETES MELLITUS
HYPERTENSION

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☑

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	26a. DATE OF INJURY (Month, Day, Year) — 26b. TIME OF INJURY — 26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO — 26d. DESCRIBE HOW INJURY OCCURED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M.D	29c. LICENSE NUMBER: D44996	29d. DATE SIGNED (Month, Day, Year): JUNE 24, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ZAFAR MALIK MD 20311 LAPPANS RD BOONSBORO MD 21713			
31. DATE FILED (Month, Day, Year): JUN 26 1995	32. REGISTRAR'S SIGNATURE		

DHMH-18 Rev 1/89

95 20132

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CHARLES EDWARD ROBINSON			2. DATE OF DEATH (Month, Day, Year): JUNE 29, 1995	3. TIME OF DEATH: 10:15 AM
4. SOCIAL SECURITY NUMBER: 217 09 9942	5. SEX: 1 [ ] M 2 [X] F	6. AGE (In yrs. last birthday): 95 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 4, 1900	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Williamsport Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: Williamsport	9c. COUNTY OF DEATH: Washington	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Hagerstown	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 7 East Washington St.		10f. ZIP CODE: 21740	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): unk. / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Watchman	16b. KIND OF BUSINESS/INDUSTRY: Museum	
17. FATHER'S NAME (First, Middle, Last): Obers Robinson	18. MOTHER'S NAME (First, Middle, Maiden Surname): unknown		
19a. INFORMANT'S NAME (Type/Print): Patricia Mulcahy	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11319 Dogwood Dr. Hagerstown, Md. 21740		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Smithsburg Crematory	20c. LOCATION — City or Town, State: Smithsburg, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Gerald N. Minnich	22. NAME AND ADDRESS OF FACILITY: Gerald N. Minnich Funeral Home, 305 N. Potomac St. Hagerstown, Md.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. METASTATIC CARCINOMA OF THE PROSTATE	YEARS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION
RECTAL CARCINOMA
GLUCOSE INTOLERANCE

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA. OTHER: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Ted Howe MD	29c. LICENSE NUMBER: D 33700	29d. DATE SIGNED (Month, Day, Year): ▶ JUNE 29, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): TED E. HOWE, M.D., 154 NORTH ARTIZAN STREET, WILLIAMSPORT, MD 21795

31. DATE FILED (Month, Day, Year): JUN 30 1995	32. REGISTRAR'S SIGNATURE: Julia Henderson Randall

DHMH-18 Rev 1/89

95 20133

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GERALD CHARLES RONAN			2. DATE OF DEATH (Month, Day, Year): June 18, 1995	3. TIME OF DEATH: 3:50 P M
4. SOCIAL SECURITY NUMBER: 198-10-1328	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Jan.22,1919	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): 6001 Ammendale Road		9b. CITY, TOWN OR LOCATION OF DEATH: Beltsville		9c. COUNTY OF DEATH: Prince Georges

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince Georges	10c. CITY, TOWN OR LOCATION: Beltsville	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 6001 Ammendale Road		10f. ZIP CODE: 20705	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 5+	15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher	16b. KIND OF BUSINESS/INDUSTRY: Religious
17. FATHER'S NAME (First, Middle, Last): Jeremiah James Ronan		18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret McDonald	
19a. INFORMANT'S NAME (Type/Print): Brother Kevin Erb,F.S.C.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6001 Ammendale Road Beltsville,Maryland 20705	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Christian Brothers Cemetery 6/22/95	20c. LOCATION — City or Town, State: Beltsville,Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Steven D Stroud		22. NAME AND ADDRESS OF FACILITY: Francis J. Collins Funeral Home, Inc. 500 University Blvd.,W. Sil.Spr.,MD 20901	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CHRONIC RENAL FAILURE	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. PENICILLIN INTERSTITIAL NEPHRITIS	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. OSTEOMYELITIS LEFT FOOT	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: DIABETES, RESTRICTIVE AND OBSTRUCTIVE LUNG DISEASE

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D22755	29d. DATE SIGNED (Month, Day, Year): ▶ 6/19/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CHRISTINE DELIMA, M.D. 7350 VAN DUSEN RD #260 Laurel, MD 20707		
31. DATE FILED (Month, Day, Year): JUN 21 1995	32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall	

DHMH-18 Rev 1/89

2

95 20134

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LILLIAN A RICH			2. DATE OF DEATH (Month, Day, Year): JUNE 18, 1995	3. TIME OF DEATH: 5:45 P M
4. SOCIAL SECURITY NUMBER: 578-30-3315	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 96 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Aug. 22, 1898	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): Washington Adventist Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Takoma Park		9c. COUNTY OF DEATH: Montgomery
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Rockville		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 5621 Lake Christopher Drive		10f. ZIP CODE: 20855		10g. CITIZEN OF WHAT COUNTRY? United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — Americen Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+): –		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker		16b. KIND OF BUSINESS/INDUSTRY: Own Home
17. FATHER'S NAME (First, Middle, Last): Congezio Mascotra		18. MOTHER'S NAME (First, Middle, Maiden Surname): Pauline Paglione		
19a. INFORMANT'S NAME (Type/Print): Peter M. Rich		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10009 Gable Manor Court, Potomac, Maryland 20854		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Arlington National Cemetery DATE: June 21, 1995		20c. LOCATION — City or Town, State: Arlington, Virginia
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Michele P. Kutta M00348		22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 W. Montgomery Ave Rockville, Maryland 20850-2805		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Atherosclerotic heart disease	20 yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
MD	D 27865	▶ 6/19/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARK K LI MD 1721 University Blvd W, Wheaton MD 20902

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 21 1995	Julia Davidson-Randall

DHMH-16 Rev 1/89

2

Amended #1 6/22/95 MRT Montgomery County 95 20135

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ~~Virginia C. Ramsay~~ Virginia Christine Ramsay			2. DATE OF DEATH (Month, Day, Year): June 20, 1995	3. TIME OF DEATH: 5:00 AM
4. SOCIAL SECURITY NUMBER: 579-22-7179	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 70 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Nov. 27, 1924	8. BIRTHPLACE (State or Foreign Country): North Carolina
9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Silver Spring	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 14564 Kelmscot Drive		10f. ZIP CODE: 20906	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): John Samuel Ledford		18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret Wingate	
19a. INFORMANT'S NAME (Type/Print): Bonnie J. Hummer	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14921 Pennfield Circle Silver Spring, Maryland 20906		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan Crematory DATE 6/21/95	20c. LOCATION — City or Town, State: Alexandria, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert E. Ramsey	22. NAME AND ADDRESS OF FACILITY: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Respiratory failure	Days
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. DUE TO (OR AS A CONSEQUENCE OF):	Chronic obstructive lung disease and	years
c. DUE TO (OR AS A CONSEQUENCE OF):	Congestive Heart Failure	
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Osteoporosis

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☒ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	26a. DATE OF INJURY (Month, Day, Year) / 26b. TIME OF INJURY M / 26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	26d. DESCRIBE HOW INJURY OCCURED
	26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Irnest S. Oser MD	29c. LICENSE NUMBER: D03792	29d. DATE SIGNED (Month, Day, Year): ▶ 6/20/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Irnest S. Oser, M.D. 10301 Georgia Avenue #304 Silver Spring, Maryland 20902

31. DATE FILED (Month, Day, Year): JUN 22 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

95 20136

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Sornshai Rodbhajon				2. DATE OF DEATH (Month, Day, Year): 6 21 1995	3. TIME OF DEATH: 7.50 AM
4. SOCIAL SECURITY NUMBER: 217-44-9907	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 75 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): April 22,1920	8. BIRTHPLACE (State or Foreign Country): Thailand
9a. FACILITY NAME (If not institution, give street and number): 8405 14th Avenue		9b. CITY, TOWN OR LOCATION OF DEATH: Hyattsville			9c. COUNTY OF DEATH: Prince George	
RESIDENCE OF DECEDENT						
10a. STATE: Maryland	10b. COUNTY: Prince George	10c. CITY, TOWN OR LOCATION: Hyattsville			10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO	
10e. STREET AND NUMBER: 8405 14th Avenue		10f. ZIP CODE: 20783			10g. CITIZEN OF WHAT COUNTRY?: Thailand	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Asian	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Occupational Engineer			16b. KIND OF BUSINESS/INDUSTRY: Engineering	
17. FATHER'S NAME (First, Middle, Last): Pai Rodbhajon					18. MOTHER'S NAME (First, Middle, Maiden Surname): Kreang Unknown	
19a. INFORMANT'S NAME (Type/Print): Suntharee R. Rodbhajon		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8405 14th Avenue Hyattsville,Maryland 20783				
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan Crematory	DATE: 6/24/95		20c. LOCATION — City or Town, State: Alexandria,Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Marsha Randall		22. NAME AND ADDRESS OF FACILITY: Francis J. Collins Funeral Home, Inc. 500 University Blvd.,W. Sil.Spr.,MD 20901				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Massive Myocardial infaretion	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] S.H.O.	D21900	▶ 6/21/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SMITH S.H.O 7610 Carroll Ave #280 Takoma Park Maryland 20912 June 21, 1995

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 22 1995	Julia Davidson Randall

DHMH-16 Rev 1/89

95 20137

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Eileen Marie Rawley		2. DATE OF DEATH (Month, Day, Year): June 19, 1995	3. TIME OF DEATH: 6:35 AM
4. SOCIAL SECURITY NUMBER: 161-24-4930	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 65 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): Oct 28, 1929
8. BIRTHPLACE (State or Foreign Country): Pennsylvania			
9a. FACILITY NAME (If not institution, give street and number): 12756 Blair Road	9b. CITY, TOWN OR LOCATION OF DEATH: Lusby	9c. COUNTY OF DEATH: Calvert	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Calvert	10c. CITY, TOWN OR LOCATION: Lusby	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: P.O. Box 143	10f. ZIP CODE: 20657	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 2 yrs.	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): Peter Edward Nugent		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Ellen O'Leary	
19a. INFORMANT'S NAME (Type/Print): John William Rawley		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 143, Lusby, Maryland 20657	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan Crematory DATE: 6/19/95	20c. LOCATION — City or Town, State: Alexandria, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michael L Gardiner		22. NAME AND ADDRESS OF FACILITY: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Glioblastoma	4 months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Diabetes, Breast Cancer
Peptic Ulcer Disease

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D38991	29d. DATE SIGNED (Month, Day, Year): ▶ June 19, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MICHAEL DIPRE 100 HOSPITAL DRIVE PRINCE FREDERICK MD		
31. DATE FILED (Month, Day, Year): JUN 20 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

AMENDED #20b, 6-17-95, CT, WASH. CO. H95H20138

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
HARVEY E. STINE			June 17 1995	1330 M
4. SOCIAL SECURITY NUMBER	**5. SEX**	**6. AGE (In yrs. last birthday)**	**7. DATE OF BIRTH (Month, Day, Year)**	**8. BIRTHPLACE (State or Foreign Country)**
220-10-3909	1 ☒ M 2 ☐ F	68 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	Dec. 5, 1926	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Washington County Hospital	Hagerstown	Washington

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Washington	Boonsboro	1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
141 South Main Street	21713	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES?	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	1 ☐ YES 2 ☒ NO Specify:	Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
0	0	no	

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Ira L. Stine	Flora Mae Moser

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mr. Jim Elliott	11223 Hollywood Drive, Hagerstown, Maryland 21740

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ____	~~Benevola Church~~ MT. ZION Cemetery DATE 6-20-95	Benevola, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Fred L Nestal	Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, MD 21740

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Congestive heart failure DUE TO (OR AS A CONSEQUENCE OF):	3 hours
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. cardiomyopathy DUE TO (OR AS A CONSEQUENCE OF):	~~1~~ year
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

renal failure

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☑

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)

1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	D32518	▶ 6-17-95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Dr. Robert Gaudet 100 Getting Lane Keedysville Md. 21756

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 19 1995	Julia Hutcheson Randall

DHMH-16 Rev 1/89

95 20139

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Max Denton SPIELMAN		2. DATE OF DEATH (Month, Day, Year): JUNE 22 1995	3. TIME OF DEATH: 0340 M
4. SOCIAL SECURITY NUMBER: 214-09-8645	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 90 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 25 1905
8. BIRTHPLACE (State or Foreign Country): Maryland			
9a. FACILITY NAME (If not Institution, give street and number): Washington County Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown	9c. COUNTY OF DEATH: Washington	
RESIDENCE OF DECEDENT			
10a. STATE: Maryland	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Hagerstown	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 821 West Washington Street	10f. ZIP CODE: 21740	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: National Guard 1920's	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0-6; College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Engineer	16b. KIND OF BUSINESS/INDUSTRY: Light Plant	
17. FATHER'S NAME (First, Middle, Last): Denton J. Spielman		18. MOTHER'S NAME (First, Middle, Maiden Surname): Melvina Myers	
19a. INFORMANT'S NAME (Type/Print): Loretta M. Spielman		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 821 W. Washington St. Hagerstown, Md. 21740	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Rose Hill Cemetery DATE: 6-26-95	20c. LOCATION — City or Town, State: Hagerstown, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert A. Haines		22. NAME AND ADDRESS OF FACILITY: Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. myocardial Infarction.	5 hrs
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): b. Coronary Artery disease	years
	DUE TO (OR AS A CONSEQUENCE OF): c. Chronic Obstructive Pulmonary	years
	DUE TO (OR AS A CONSEQUENCE OF): d. Aortic Abdominal Aneurysm Disease	years

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Prostate Cancer with bone metastasis

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA. OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) WCH

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one):
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] MD

29c. LICENSE NUMBER: D45031

29d. DATE SIGNED (Month, Day, Year): 6 29 95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): [illegible] MD. 19414 Leitersburg Pike Hag MD.

31. DATE FILED (Month, Day, Year): JUN 23 1995

32. REGISTRAR'S SIGNATURE: Julie Davidson Randall

DHMH-16 Rev 1/89

95 20140

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Anna Mabel STOCKSLAGER			2. DATE OF DEATH (Month, Day, Year): 6 29 95	3. TIME OF DEATH: 1116A M
4. SOCIAL SECURITY NUMBER: 214-09-0059	5. SEX: 1 ☐ M 2 ☒ F	8. AGE (In yrs. last birthday): 83 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): March 1, 1912	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Washington County Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown		9c. COUNTY OF DEATH: Washington
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Sharpsburg		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 232 W. Main St.		10f. ZIP CODE: 21782		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Legal Secretary		16b. KIND OF BUSINESS/INDUSTRY: Law Firm
17. FATHER'S NAME (First, Middle, Last): Stewart Whitfield Grayson		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mabel Lillian Cramer		
19a. INFORMANT'S NAME (Type/Print): Lilly M. Grayson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O.Box 116 Sharpsburg, MD. 21782		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. View Cemetery DATE: June 27, 1995		20c. LOCATION — City or Town, State: Sharpsburg, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]		22. NAME AND ADDRESS OF FACILITY: Osborne Funeral Home P.O.Box 348 Williamsport, Md. 21795		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ANEMIA	10 Days
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF): No Oral Intake	10 Days
	c. DUE TO (OR AS A CONSEQUENCE OF): MASSIVE STROKE	6 [illegible] 95
	d. DUE TO (OR AS A CONSEQUENCE OF): ACUTE THROMBOSIS	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: RECENT FRACTURE RIGHT HIP; CORONARY ARTERY DISEASE

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] Family Doctor Covering For Dr. Kugler	D17067	▶ 6/24/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): STEPHEN E. METZGER, MD 740 Northern Ave Hagerstown MD

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 26 1995	[signature]

DHMH-16 Rev 1/89

95 20141

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEOENT'S NAME (First, Middle, Last): Frederick Lloyd Slick,Jr.			2. DATE OF DEATH (Montn, Day, Year): June 25,1995	3. TIME OF DEATH: 0800 M
4. SOCIAL SECURITY NUMBER: 216-22-1651	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 67 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Dec.28,1927	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street end number): 11237 Marbern Rd.		9b. CITY, TOWN OR LOCATION OF DEATN: Hagerstown	9c. COUNTY OF DEATH: WASHINGTON	
RESIDENCE OF DECEDENT				
10e. STATE: Maryland	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Hagerstown	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO	
10a. STREET AND NUMBER: 11237 Marbern Rd.		10f. ZIP CODE: 21740	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: 3/30/46---2-5-48	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Manager	16b. KIND OF BUSINESS/INDUSTRY: Super Market		
17. FATHER'S NAME (First, Middle, Last): Frederick Lloyd Slick,Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Elsie Irene Barnhart		
19a. INFORMANT'S NAME (Type/Print): Patricia L.Slick		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11237 Marbern Rd.Hagerstown,MD 21740		
20a. METNOD OF OISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Ramoval from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF OISPOSITION (Name of cemetery, crematory or other place): Greenlawn Memorial Park	DATE: June 28,1995	20c. LOCATION (City or Town, State): Williamsport,MD 21795	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: OSBORNE FUNERAL HOME P.O.Box # 348 Williamsport,MD 21795		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, Dr complications that caused the death. Dd not enter the mode of dying, such as cardiac Dr reapiratDry arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease Dr condition resulting in death) → a.	PROGRESSIVE RESPIRATORY FAILURE	10 HRS
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease Dr injury that initiated events resulting in death) LAST — b.	METASTATIC CANCER (SUSPECT LUNG PRIMARY)	2 MONTHS
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditiona contributing to death but not reaulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [X] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATN (Check only one)
HOSPITAL: 1 [ ] Inpatiant 2 [X] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Nome 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF OEATH: 1 [X] Natural ? 2 [ ] Accident 3 [ ] Suicide 4 [ ] Nomicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. OATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE NOW INJURY OCCURED
N/A	N/A M	1 [ ] YES 2 [ ] NO	N/A

28e. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify): N/A

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date end place, and due to the ceuse(s) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] MD.	BC3013377	▶ June 26,1995

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print): Dan Cornell,MD 251 E.Antietam St. Hagerstown,MD 21740

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 28 1995	[signature]

DHMH-16 Rev 1/89

95 20142

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Carl William Shupp			2. DATE OF DEATH (Month, Day, Year): June 23, 1995	3. TIME OF DEATH: 9:15 P. M
4. SOCIAL SECURITY NUMBER: 217-18-7932	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 79 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): July 26, 1915	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 280 S. Prospect Street		9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown		9c. COUNTY OF DEATH: Washington
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Hagerstown		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 280 S. Prospect Street		10f. ZIP CODE: 21740		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 4 / College (1-4 or 8+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): driver	16b. KIND OF BUSINESS/INDUSTRY: county roads dept.		
17. FATHER'S NAME (First, Middle, Last): Andrew Smith Shupp		18. MOTHER'S NAME (First, Middle, Maiden Surname): Bertha Mae Staley		
19a. INFORMANT'S NAME (Type/Print): Margaret E. Shupp		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 280 S. Prospect Street Hagerstown, Maryland 21740		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Lawn Memorial Park	DATE: 6/28	20c. LOCATION — City or Town, State: Hagerstown, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Gerald N. Minnich	22. NAME AND ADDRESS OF FACILITY: Gerald N. Minnich Funeral Home	305 N. Potomac Street Hagerstown, Maryland		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Carcinoma Lung	6 months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive Pulmonary Disease

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [X] NO [ ] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD | 29c. LICENSE NUMBER: D41786 | 29d. DATE SIGNED (Month, Day, Year): 6/26/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. Meuchery MD, 12821 Oakhill avenue, Hagerstown, MD 21740

31. DATE FILED (Month, Day, Year): JUN 27 1995 | 32. REGISTRAR'S SIGNATURE: Julia [illegible] Randall

DHMH-16 Rev 1/89

95 20143

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RONALD ELLSWORTH SMITH			2. DATE OF DEATH (Month, Day, Year): June 23, 1995	3. TIME OF DEATH: 0200 M
4. SOCIAL SECURITY NUMBER: 219-20-4489	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 67 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 29, 1928	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 17028 Oakleigh Way		9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown		9c. COUNTY OF DEATH: Washington
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Hagerstown		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 17028 Oakleigh Way		10f. ZIP CODE: 21740		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: Korea	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9 years; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Truck Driver		16b. KIND OF BUSINESS/INDUSTRY: Trucking Company
17. FATHER'S NAME (First, Middle, Last): Charles A. Smith		18. MOTHER'S NAME (First, Middle, Maiden Surname): Eva Grams		
19a. INFORMANT'S NAME (Type/Print): Richard W. Smith		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17027 Oakleigh Way Hagerstown, Maryland 21740		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Lawn Mem. Park DATE 6-26-1995		20c. LOCATION — City or Town, State: Hagerstown, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Douglas A. Fiery		22. NAME AND ADDRESS OF FACILITY: Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, Md.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic Cardio Vascular Disease	15 yrs. approx.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellities Type II

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Edward W. DiTto	29c. LICENSE NUMBER: DO 1062	29d. DATE SIGNED (Month, Day, Year): ▶ June 25, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Edward W. Ditto III 217 West Washington Street hagerstown, Maryland 21740		
31. DATE FILED (Month, Day, Year): JUN 26 1995	32. REGISTRAR'S SIGNATURE	

OHMH-16 Rev 1/89

ITEM: 7. PER F.H. FILM G-725 7/27/95 t.t

95 20144

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WILLIAM QUAIL SMITH			2. DATE OF DEATH (Month, Day, Year): JUNE 19, 1995	3. TIME OF DEATH: 5:55 PM
4. SOCIAL SECURITY NUMBER: 217 10 7558	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 77 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH: JUNE 12,1918 ~~FEBRUARY 11,1918~~	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND		9c. COUNTY OF DEATH: ALLEGANY
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: ALLEGANY	10c. CITY, TOWN OR LOCATION: FROSTBURG		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 12113 WALL STREET, SW		10f. ZIP CODE: 21532		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): TEXTILE DEPARTMENT		16b. KIND OF BUSINESS/INDUSTRY: CELANESE CORP.
17. FATHER'S NAME (First, Middle, Last): ADAM SMITH			18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY BARCLAY	
19a. INFORMANT'S NAME (Type/Print): MARY MAXINE SMITH		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12113 WALL STREET, SW, FROSTBURG, MD 21532		
20a. METHOD OF DISPOSITION: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): SUNSET MEMORIAL PARK,	DATE: JUNE 23,1995	20c. LOCATION — City or Town, State: CUMBERLAND, MD 21502
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Marilou M. Sowers		22. NAME AND ADDRESS OF FACILITY: SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. acute Massive Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF):	1 hr
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Excision abdominal aortic aneurysm DUE TO (OR AS A CONSEQUENCE OF):	6 hrs
	c. arteriosclerosis DUE TO (OR AS A CONSEQUENCE OF):	20 yrs.
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Iliac artery aneurysm - aortic iliac occlusive disease

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D13233	29d. DATE SIGNED (Month, Day, Year): JUNE 20, 95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A. SIVAN PILLAI M.D. 915 Seton Dr. Cumberland MD. 21502		
31. DATE FILED (Month, Day, Year): JUN 23 1995	32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall	

DHMH-16 Rev 1/89

4

3

95 20145

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
GEORGIA	IRIS	SCARPELLI	JUNE 20, 1995	09:00 AM

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
220-10-9330	1 ☐ M 2 ☒ F	81 YRS.			August 5,1913	West Virginia

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Sacred Heart Hospital	Cumberland	Allegany

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Allegany	Frostburg	1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
337 Allegany Street	21532	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12	0	Waitress	Restaurant

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
William Thomas Wilhelm	Effie Caroline Garlitz

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Joseph M. Scarpelli	337 Allegany Street Frostburg, Maryland 21532

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Cumberland Crematory	June 20,95	Cumberland,Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ John R. Durst	Durst Funeral Home 57 Frost Avenue Frostburg, Maryland 21532

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heert feilure. List only one ceuse on eech line.

		Approximate Interval Between Onset end Death
IMMEDIATE CAUSE (Final diseese or condition resulting in death) →	a. End Stage Chronic lung disease	3 mos
Sequentially list conditions, if any, leeding to immediete cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	

28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(s) end manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Gary Wagoner MD	D22181	▶ JUNE 20,1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DR. GARY WAGONER, M.D., 925 BISHOP WALSH ROAD, CUMBERLAND, MD 21502

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 21 1995	John Matthew Randall

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DHMH-16 Rev 1/89

95 20146

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EARL Jennings SHANHOLTZ			2. DATE OF DEATH (Month, Day, Year): JUNE 12 1995	3. TIME OF DEATH: 21:38 PM
4. SOCIAL SECURITY NUMBER: 215-20-5352	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 71 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): April 23,1924	8. BIRTHPLACE (State or Foreign Country): West Virginia
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland		9c. COUNTY OF DEATH: Allegany

RESIDENCE OF DECEDENT

10a. STATE: WV	10b. COUNTY: Hampshire	10c. CITY, TOWN OR LOCATION: Greenspring	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: HC 86, Box 54		10f. ZIP CODE: 26722	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: World War II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Carpenter	16b. KIND OF BUSINESS/INDUSTRY: Rail Road	
17. FATHER'S NAME (First, Middle, Last): Wilbur J. Shanholtz		18. MOTHER'S NAME (First, Middle, Maiden Surname): Edna Lee Wagoner	
19a. INFORMANT'S NAME (Type/Print): Phyllis Shanholtz	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): HC 86, Box 54, Greenspring, WV 27822		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Forest Glen Cemetery, DATE: June 15,1995	20c. LOCATION — City or Town, State: Greenspring, WV	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Sarah Morgan	22. NAME AND ADDRESS OF FACILITY: Shaffer Funeral Home, Inc. 230 East Main St., Romney, WV 26757		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Multi-Organ Failure	4 days
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Sepsis	4 days
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Right Hepatic Lobectomy	2 weeks
DUE TO (OR AS A CONSEQUENCE OF):		
d.	Metastatic Colon Carcinoma	2 years

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [✓] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [✓]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO

28. PLACE OF DEATH (Check only one): HOSPITAL: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
	M	1 [ ] YES 2 [ ] NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Kenneth Hood MD	D 17456	6/13/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. PHILIP SCHROEDER, 600 MEMORIAL AVE., CUMBERLAND, MD 21502

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 19 1995	Jean E. Bittner-Randall

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DHMH-16 Rev 1/89

95 20147

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Robert Joseph Snyder Sr.			2. DATE OF DEATH (Month / Day / Year): June 10 95	3. TIME OF DEATH: 7:45 PM
4. SOCIAL SECURITY NUMBER: 214-05-4923	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 83 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Mar 11, 1912	8. BIRTHPLACE (State or Foreign Country): PA
9a. FACILITY NAME (If not institution, give street and number): ARUNDEL MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: ANNAPOLIS		9c. COUNTY OF DEATH: ANNE ARUNDEL

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Cumberland	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 31 Massachusetts Avenue		10f. ZIP CODE: 21502	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Machinist	16b. KIND OF BUSINESS/INDUSTRY: Tire Company	
17. FATHER'S NAME (First, Middle, Last): Frank C. Snyder		18. MOTHER'S NAME (First, Middle, Maiden Surname): Anne (Stanton)	
19a. INFORMANT'S NAME (Type/Print): Mary Anne Kuehn	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 531 WILSON ROAD; ANNAPOLIS, MD 21401		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): St. Mary's Cemetery	DATE: 06/14	20c. LOCATION — City or Town, State: Cumberland, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James J Scarpelli	22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home Cumberland, MD 21502		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Probable Pulmonary embolism	seconds
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Total knee replacement	2 day
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Hypertension	10 years
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. ASCVD	10 years

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Prostatic disease

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Allen C. Goff MD	29c. LICENSE NUMBER: D 02924	29d. DATE SIGNED (Month, Day, Year): ▶ 6/10/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Allen C. Goff MD 25 SHAW ST, ANNAPOLIS, Md. 21401

31. DATE FILED (Month, Day, Year): JUN 14 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DHMH-16 Rev 1/89

95 20148

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): AVIS GWENDOLYN SIEHLER
2. DATE OF DEATH: MONTH JUNE DAY 12, YEAR 1995
3. TIME OF DEATH: 3:20 P M
4. SOCIAL SECURITY NUMBER: 214-07-3340
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 79 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): FEB 23 1916
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND
9c. COUNTY OF DEATH: ALLEGANY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: ALLEGANY
10c. CITY, TOWN OR LOCATION: CUMBERLAND
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 13104 ROCKY GAP ROAD N.E.
10f. ZIP CODE: 21502
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSE KEEPER
16b. KIND OF BUSINESS/INDUSTRY: HOUSE KEEPER
17. FATHER'S NAME (First, Middle, Last): MERWIN R. HAST SR.
18. MOTHER'S NAME (First, Middle, Maiden Surname): JESSIE BEULAH RICE
19a. INFORMANT'S NAME (Type/Print): JACK SIEHLER
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13104 ROCKY GAP ROAD N.E. CUMBERLAND MARYLAND 21502
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): HILLCREST CEMETERY JUNE 15 DATE 1995
20c. LOCATION — City or Town, State: CUMBERLAND MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Dale L. Merritt
22. NAME AND ADDRESS OF FACILITY: MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Respiratory failure	7 to 7 days
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b.	lymphoma, progressive with abdominal involvement	5 years
DUE TO (OR AS A CONSEQUENCE OF): c.		
DUE TO (OR AS A CONSEQUENCE OF): d.	CHF - A. Fibrillation	7 5 years

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
26a. DATE OF INJURY (Month, Day, Year)
26b. TIME OF INJURY M
26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
26d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: John Mehanna M.D.
29c. LICENSE NUMBER: D-17526
29d. DATE SIGNED (Month, Day, Year): ▶ JUNE 13-95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. JOHN MEHANNA, M.D., 909-B SETON DRIVE, CUMBERLAND, MD 21502
31. DATE FILED (Month, Day, Year): JUN 13 1995
32. REGISTRAR'S SIGNATURE: Judi Davidson Rachell

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OHMH-16 Rev 1/89

8/2 95M20149

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Sylvia Schaeffer			2. DATE OF DEATH (Month, Day, Year): JUN 23, 1995	3. TIME OF DEATH: 810 A M
4. SOCIAL SECURITY NUMBER: 214-36-1905	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 80 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): SEPT. 20, 1914	8. BIRTHPLACE (State or Foreign Country): NEW YORK
9a. FACILITY NAME (If not institution, give street and number): MONTGOMERY GENERAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: OLNEY	9c. COUNTY OF DEATH: MONTGOMERY	
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: SILVER SPRING	10d. INSIDE CITY LIMITS? ☒ 1 YES 2 ☐ NO	
10e. STREET AND NUMBER: 15300 BEAVERBROOK COURT 2H		10f. ZIP CODE: 20906	10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): OFFICE WORKER	16b. KIND OF BUSINESS/INDUSTRY: RETAIL		
17. FATHER'S NAME (First, Middle, Last): "UNKNOWN" BLOCK		18. MOTNER'S NAME (First, Middle, Maiden Surname): IDA RUBENSTEIN		
19a. INFORMANT'S NAME (Type/Print): PHILIP SCHAEFFER (HUSBAND)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15300 BEAVERBROOK CT. 2H-SILVER SPRING, MD. 20906		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place): KING DAVID MEMORIAL GARDEN	DATE: 6/23	20c. LOCATION — City or Town, State: FALLS CHURCH, VA.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Frank A Stone		22. NAME AND ADDRESS OF FACILITY: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MD. 20852		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Colon Cancer	four months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] MD

29c. LICENSE NUMBER: D33688

29d. DATE SIGNED (Month, Day, Year): ▶ June 22 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): [illegible] MD 18111 Prince Phillip Dr. Olney, MD 20832

31. DATE FILED (Month, Day, Year): JUN 23 1995

32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DNMN-16 Rev 1/89

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95 20150

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Rumpa Singh			2. DATE OF DEATH (Month, Day, Year): June 20, 1995	3. TIME OF DEATH: 8:25 p M
4. SOCIAL SECURITY NUMBER: 215-25-0763	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 79 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Aug. 23, 1915	8. BIRTHPLACE (State or Foreign Country): India
9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring	9c. COUNTY OF DEATH: Montgomery	
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Silver Spring	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER: 12740 Bexley Terrace		10f. ZIP CODE: 20904	10g. CITIZEN OF WHAT COUNTRY? Perm. Resident United States	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Asian Indian	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0 College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY: Home		
17. FATHER'S NAME (First, Middle, Last): Mawasy Das		18. MOTHER'S NAME (First, Middle, Maiden Surname): Kaliya Singh		
19a. INFORMANT'S NAME (Type/Print): Kezia V. Singh	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1415 Milestone Drive, Silver Spring, Maryland 20904			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): George Washington Cem. DATE: 6/22	20c. LOCATION — City or Town, State: Adelphi, Md		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Philip D Rinaldi	22. NAME AND ADDRESS OF FACILITY: Hines/Rinaldi Funeral Home 11800 New Hampshire Ave. Silver Spring, Md.			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute respiratory failure	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): b. Chronic obstructive pulmonary Disease	
	DUE TO (OR AS A CONSEQUENCE OF): c.	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	26a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY M	26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	26d. DESCRIBE HOW INJURY OCCURED		
	26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: G. Gupta, M.D.	29c. LICENSE NUMBER: MD 46398	29d. DATE SIGNED (Month, Day, Year): ▶ June 21, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 121 Congressional Lane, Suite 409, Rockville MD 20852		
31. DATE FILED (Month, Day, Year): JUN 23 1995	32. REGISTRAR'S SIGNATURE: Julie Dunbar Kimball	

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DHMH-16 Rev 1/89

95 20151

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DORA SCHNEIDERMAN			2. DATE OF DEATH (Month, Day, Year): June 16, 1995	3. TIME OF DEATH: 7:55 P. M
4. SOCIAL SECURITY NUMBER: 122-30-0016	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 92 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): March 13, 1903	8. BIRTHPLACE (State or Foreign Country): Russia
9a. FACILITY NAME (If not institution, give street and number): Hebrew Home of Greater Washington		9b. CITY, TOWN OR LOCATION OF DEATH: Rockville		9c. COUNTY OF DEATH: Montgomery
RESIDENCE OF DECEDENT				
10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION: Washington, D.C.		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 4702 Foxhall Crescents, N.W.		10f. ZIP CODE: 20007		10g. CITIZEN OF WHAT COUNTRY? United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary		16b. KIND OF BUSINESS/INDUSTRY: Insurance Company
17. FATHER'S NAME (First, Middle, Last): Joseph Alpert		18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Horowitz		
19a. INFORMANT'S NAME (Type/Print): Milton Schneiderman		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as #10		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Mount Golda Cemetery	DATE: 6/19	20c. LOCATION — City or Town, State: Huntington Station, N.Y.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ellen H. Rapp		22. NAME AND ADDRESS OF FACILITY: Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, MD 20910		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications thet ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

		Approximate interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition resulting in death) →	a. Respiratory Failure	1 Immediate
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Pneumonia	2½ weeks
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) —

28b. TIME OF INJURY — M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) —

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
for Paul Kretting MD	021435	▶ June 17, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Paul Kretting 2101 Medical Park Dr Silver Spring MD 20902

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 19 1995	Julia Davidson-Randall

DHMH-16 Rev 1/89

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Amended #31 6/19/95 MRT Montgomery County

Error

95 201572

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ROBERT WILLIAM SAPORA, SR.			2. DATE OF DEATH (Month, Day, Year): JUNE 15 1995	3. TIME OF DEATH: ~4:00 AM
4. SOCIAL SECURITY NUMBER: 332-07-2227	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 80 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): March 12, 1915	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): 9200 Edwards Way #1111		9b. CITY, TOWN OR LOCATION OF DEATH: Adelphi		9c. COUNTY OF DEATH: PRINCE GEORGE'S

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince Georges	10c. CITY, TOWN OR LOCATION: Adelphi	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 9200 Edwards Way #1111		10f. ZIP CODE: 20783	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WW 11	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Advertising Manager	16b. KIND OF BUSINESS/INDUSTRY: Advertising Agency
17. FATHER'S NAME (First, Middle, Last): Joseph Sapora		18. MOTHER'S NAME (First, Middle, Maiden Surname): Gizella Culhanik	
19a. INFORMANT'S NAME (Type/Print): Robert W. Sapora, Jr.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 825 Holliday Lane Westminster, MD 21157	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitian Crematory June 17 DATE: 1995	20c. LOCATION — City or Town, State: Alexandria, VA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dyga L Hilbert		22. NAME AND ADDRESS OF FACILITY: Takoma Funeral Home, Inc. 254 Carroll St. NW Washington, D.C. 20012	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. HYPERTENSION	years.
DUE TO (OR AS A CONSEQUENCE OF):		
	c.	
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: J Berger MD	29c. LICENSE NUMBER: D25925	29d. DATE SIGNED (Month, Day, Year): ▶June 16, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J BERGER MD #205, 7720 WISCONSIN Ave Bethesda, Md 20814		
31. DATE FILED (Month, Day, Year): JUN 19 1995	32. REGISTRAR'S SIGNATURE: Julia Gardner Randall	

DHMH-18 Rev 1/89

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95 20153

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Antonio Sanchez				2. DATE OF DEATH (Month, Day, Year): June 15 1995	3. TIME OF DEATH: 11:04 P M
4. SOCIAL SECURITY NUMBER: 218-11-2688	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 71 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): MARCH 16, 1924	8. BIRTHPLACE (State or Foreign Country): PERU
9a. FACILITY NAME (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: ROCKVILLE		9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: ROCKVILLE	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 12407 BRAXFIELD COURT		10f. ZIP CODE: 20852	10g. CITIZEN OF WHAT COUNTRY?: PERU

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [X] YES 2 [ ] NO Specify: PERUVIAN	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): OWNER - OPERATOR	16b. KIND OF BUSINESS/INDUSTRY: RESTAURANT
17. FATHER'S NAME (First, Middle, Last): ANTONIO SANCHEZ SR.		18. MOTHER'S NAME (First, Middle, Maiden Surname): MERCEDES ROMERO	
19a. INFORMANT'S NAME (Type/Print): GLORIA SANCHEZ		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12407 BRAXFIELD COURT #5 ROCKVILLE, MD. 20852	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): GATE OF HEAVEN CEMETERY DATE: 6/21/95	20c. LOCATION — City or Town, State: SILVER SPRING, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Muriel H. Barber		22. NAME AND ADDRESS OF FACILITY: MURIEL H. BARBER FUNERAL HOME 20882 P.O. BOX 5038 LAYTONSVILLE, MARYLAND	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Gastrointestinal Bleeding	One week
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Gastric Cancer	Four Months
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [X] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] MD	29c. LICENSE NUMBER: 033586	29d. DATE SIGNED (Month, Day, Year): June 15, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Kenneth Milks, MD 18111 Ponce Philip Dr. Olney, MD 20832

31. DATE FILED (Month, Day, Year): JUN 19 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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95 20154

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DOROTHY SOTAK				2. DATE OF DEATH (Month, Day, Year): JUNE 18, 1995	3. TIME OF DEATH: 13:33 M
4. SOCIAL SECURITY NUMBER: 230-14-3811	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 85 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): June 12, 1910	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Washington Adventist Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Takoma Park		9c. COUNTY OF DEATH: Prince Georges

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Takoma Park	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 7051 Carroll Avenue		10f. ZIP CODE: 20912	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Nurse	16b. KIND OF BUSINESS/INDUSTRY: Private Home Care	
17. FATHER'S NAME (First, Middle, Last): Pembrooke Richardson		18. MOTHER'S NAME (First, Middle, Maiden Surname): Rosa Clavoine Hayes	
19a. INFORMANT'S NAME (Type/Print): Linda D. Amick	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): HC63 Box 29C Leivasy, West Virginia 26676		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan Crematory	DATE: 6/19/95	20c. LOCATION — City or Town, State: Alexandria, VA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Steven D Stroud	22. NAME AND ADDRESS OF FACILITY: Francis J. Collins Funeral Home, Inc. 500 University Blvd.W. Sil.Spr.MD 20901		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Acute pulmonary edema	1 Day
DUE TO (OR AS A CONSEQUENCE OF):	Cardiomyopathy	1 year
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.		
DUE TO (OR AS A CONSEQUENCE OF):	Arrythmia	1 Day
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: O Kwon	29c. LICENSE NUMBER: D-30927	29d. DATE SIGNED (Month, Day, Year): ▶ 6/16/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): OKi Kwon M.D. 1104 Spring St. #201. Silver Spring MD 20910

31. DATE FILED (Month, Day, Year): JUN 20 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

95 20155

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Z. SIGMUND SACHS		2. DATE OF DEATH (Month, Day, Year): 6 16 95	3. TIME OF DEATH: 7 49 A M
4. SOCIAL SECURITY NUMBER: 219-01-6171	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 72 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): AUGUST 6, 1922
8. BIRTHPLACE (State or Foreign Country): MARYLAND			
9a. FACILITY NAME (If not institution, give street and number): HOLY CROSS HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH: SILVER SPRING	9c. COUNTY OF DEATH: MONTGOMERY	

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: SILVER SPRING	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO
10e. STREET AND NUMBER: 324 APPLEGROVE ROAD	10f. ZIP CODE: 20904	10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES	

11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CERTIFIED PUBLIC ACCOUNTANT	16b. KIND OF BUSINESS/INDUSTRY: ACCOUNTING	
17. FATHER'S NAME (First, Middle, Last): HERMAN I. SACHS	18. MOTHER'S NAME (First, Middle, Maiden Surname): LILLIAN RADESKY		
19a. INFORMANT'S NAME (Type/Print): SYLVIA K. SACHS (WIFE)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 324 APPLEGROVE ROAD - SILVER SPRING, MD. 20904		
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): UNITED HEBREW CEMETERY	DATE: 6/18	20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Barry N. Gair	22. NAME AND ADDRESS OF FACILITY: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MD. 20852		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Coronary Heart Disease	years
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Diabetes Mellitus	years
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypoxic Encephalopathy
Congestive Heart Failure

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Herman B Segal MD	29c. LICENSE NUMBER: D25808	29d. DATE SIGNED (Month, Day, Year): ▶ 6/16/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Herman B Segal MD 10313 Oregon Ave Silver Spring MD 20902		
31. DATE FILED (Month, Day, Year): JUN 20 1995	32. REGISTRAR'S SIGNATURE: Jobi Davidson-Randall	

DHMH-16 Rev 1/89

95 20156

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARIO M SEGRETI				2. DATE OF DEATH (Month, Day, Year): JUNE 17 95	3. TIME OF DEATH: 00:18A M
4. SOCIAL SECURITY NUMBER: 578.01.7950	5. SEX: 1 [X] M 2 [ ] F	8. AGE (In yrs. last birthday): 80 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): MAY 5,1915	8. BIRTHPLACE (State or Foreign Country): ITALY
9a. FACILITY NAME (If not institution, give street and number): SURBURBAN HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: BETHESDA		9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: BETHESDA	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 4605 COOPER LANE		10f. ZIP CODE: 20816	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WWII ARMY	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4 or 5+): +4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): RESTAURANT	16b. KIND OF BUSINESS/INDUSTRY: SELF-EMPLOYED	
17. FATHER'S NAME (First, Middle, Last): JOSEPH SEGRETI		18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNUNZITA MAILE	
19a. INFORMANT'S NAME (Type/Print): ANITA L. SEGRETI		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4605 COOPER LANE BETHESDA, MD. 20816	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): GATE OF HEAVEN CEMETERY	DATE: 6/21	20c. LOCATION — City or Town, State: SILVER SPRING, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Leah M Peters		22. NAME AND ADDRESS OF FACILITY: 5130 WI AVE. N.W. WASHINGTON D.C. 20016 JOSEPH GAWLER'S SONS	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. SUBDURAL HEMATOMA	6 HRS.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. FALL	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [ ] NO	1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)			
27. MANNER OF DEATH: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): JUNE 16 95	28b. TIME OF INJURY: 5 M	28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO	28d. DESCRIBE HOW INJURY OCCURED: FELL DOWN STEPS
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): HOME			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): #10

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Francis C Mayle MD	D070099	▶ JUNE 17 95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): FRANCIS C MAYLE 1025 FERNWOOD RD BETHESDA MD 20817

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 20 1995	Julia Davidson Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12

95 20157

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ROGER EVERETT SPEER
2. DATE OF DEATH (Month, Day, Year): JUNE 16 1995
3. TIME OF DEATH: 1 45 PM
4. SOCIAL SECURITY NUMBER: 579-18-5669
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 73 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): Nov. 3, 1921
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Suburban Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda
9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Montgomery
10c. CITY, TOWN OR LOCATION: Rockville
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 4818 Oxbow Road
10f. ZIP CODE: 20852
10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Technician
16b. KIND OF BUSINESS/INDUSTRY: Television
17. FATHER'S NAME (First, Middle, Last): Preston Speer
18. MOTHER'S NAME (First, Middle, Maiden Surname): Ruth Margaret Owens
19a. INFORMANT'S NAME (Type/Print): Kathryn L. Speer
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4818 Oxbow Road, Rockville, Maryland 20852
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Gate of Heaven Cemetery | DATE: 6/19
20c. LOCATION — City or Town, State: Silver Spring, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Michael A. Cubbas
22. NAME AND ADDRESS OF FACILITY: DeVol Funeral Home, 10 E.Deer Park Dr., Gaithersburg, MD. 20877

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Pneumonia	2 weeks
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	emphysema	10 yrs
DUE TO (OR AS A CONSEQUENCE OF):		
c.	tobacco smoking	50 yrs
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [X] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: D33443
29d. DATE SIGNED (Month, Day, Year): Jun 16, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Alan R Pollack MD 809 Views Mill Rd Rockville Md 20851
31. DATE FILED (Month, Day, Year): JUN 21 1995
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1271

95 20158

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEOENT'S NAME (First, Middle, Last): MILDRED BERTHA STOGNER
2. DATE OF OEATH (Month, Day, Year): June 17, 1995
3. TIME OF OEATH: 8:50 P M
4. SOCIAL SECURITY NUMBER: 579-20-7941
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 78 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): May 11, 1917
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Kensington Gardens Nursing Center
9b. CITY, TOWN OR LOCATION OF DEATH: Kensington
9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Calvert
10c. CITY, TOWN OR LOCATION: Lusby
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 12962 Mohawk Drive
10f. ZIP COOE: 20657
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. OECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 3; College (1-4 or 5 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk
16b. KIND OF BUSINESS/INDUSTRY: Insurance
17. FATHER'S NAME (First, Middle, Last): Everett Jack Sypult
18. MOTHER'S NAME (First, Middle, Maiden Surname): Alice Ruth Lewis
19a. INFORMANT'S NAME (Type/Print): Martha A. Bliss
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12962 Mohawk Drive Lusby, Maryland 20657
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place): Metropolitan Crematory DATE: 6/19/95
20c. LOCATION — City or Town, State: Alexandria,Virginia
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Steven D Stuard
22. NAME AND ADDRESS OF FACILITY: Francis J. Collins Funeral Home, Inc. 500 University Blvd.,W. Sil.Spr.,MD 20901

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory srrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition resulting in death) → a.	Adenocarcinoma, Colon, Metastatic	4 Years
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Congestive Heart Failure	4 Years
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Diabetes Mellitus, Type II	4 Years
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive Pulmonary Disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: George B Patrick M D
29c. LICENSE NUMBER: D 09447
29d. OATE SIGNED (Month, Day, Year): ▶ June 17, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): George B. Patrick, Jr. M.D. 9221 Colesville Road Silver Spring,Maryland 20910
31. DATE FILED (Month, Day, Year): JUN 21 1995
32. REGISTRAR'S SIGNATURE: Julia Davidson Ruddell

OHMH-16 Rev 1/89

10

95 20159

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Warren Eugene Show			2. DATE OF DEATH (Month, Day, Year): JUNE 16 1995	3. TIME OF DEATH: 8:00 PM
4. SOCIAL SECURITY NUMBER: 172 18 4759	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Aug. 26, 1918	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): 13002 Valleywood Drive		9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Silver Spring	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 13002 Valleywood Drive		10f. ZIP CODE: 20906	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: World War II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): – ; College (1-4 or 5+): 5+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Mechanical Engineer	16b. KIND OF BUSINESS/INDUSTRY: Government Contracting	
17. FATHER'S NAME (First, Middle, Last): Ira W. Show		18. MOTHER'S NAME (First, Middle, Maiden Surname): Joetta Hall	
19a. INFORMANT'S NAME (Type/Print): Winifred B. Show	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13002 Valleywood Drive, Silver Spring, MD 20906		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Gate of Heaven Cemetery DATE: JUne 20, 1995	20c. LOCATION — City or Town, State: Silver Spring, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: M00689	22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. METASTATIC DUODENAL CARCINOMA	18 mo.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD	29c. LICENSE NUMBER: D29675	29d. DATE SIGNED (Month, Day, Year): 6/18/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RALPH V. BOCCIA MD 9707 MEDICAL CENTER DR ROCKVILLE MD		
31. DATE FILED (Month, Day, Year): JUN 21 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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95 20160

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Louis Robert Sepulveda, Sr.		2. DATE OF DEATH (Month, Day, Year): June 26, 1995	3. TIME OF DEATH: 3:12 p. M
4. SOCIAL SECURITY NUMBER: 571-05-6915	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 85 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 14, 1910
8. BIRTHPLACE (State or Foreign Country): California			
9a. FACILITY NAME (If not institution, give street and number): Residence	9b. CITY, TOWN OR LOCATION OF DEATH: Colton's Point	9c. COUNTY OF DEATH: St. Mary's	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: St. Mary's	10c. CITY, TOWN OR LOCATION: Colton's Point	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: P.O. Box 174	10f. ZIP CODE: 20626-0174	10g. CITIZEN OF WHAT COUNTRY?: United States	

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 [X] YES 2 [ ] NO Specify: Mexican	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): U.S. Park Policeman	16b. KIND OF BUSINESS/INDUSTRY: U.S. Interior/ National Park Service	
17. FATHER'S NAME (First, Middle, Last): Ysaiss Sepulveda	18. MOTHER'S NAME (First, Middle, Maiden Surname): Ygnacia Garcia		
19a. INFORMANT'S NAME (Type/Print): Louis R. Sepulveda, Jr.	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5950 Lamay Road, Rockville, Maryland 20851		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place): Charles Memorial Gardens	DATE: 6-29-95	20c. LOCATION — City or Town, State: Leonardtown, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Edward N. Brinsfield, Jr., M00052	22. NAME AND ADDRESS OF FACILITY: Brinsfield Funeral Home, P.A. 59 N. Washington St., Leonardtown, MD 20650-0279		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Congestive Heart Failure	04/95
	DUE TO (OR AS A CONSEQUENCE OF):	Date of
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	Onset
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D36206	29d. DATE SIGNED (Month, Day, Year): 6/29/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Kiran D. Mehta, M.D., Shanti Medical Center, Leonardtown, Maryland 20650		
31. DATE FILED (Month, Day, Year): JUN 29 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

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95 20161

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEOENT'S NAME (First, Middle, Last): ALOYSIUS GONZAGA SPALDING		2. DATE OF DEATH (Month, Day, Year): JUNE 25 1995	3. TIME OF DEATH: 6.00 P.M
4. SOCIAL SECURITY NUMBER: 220-32-6539	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 62 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Feb. 14, 1933
8. BIRTHPLACE (State or Foreign Country): Maryland			
9a. FACILITY NAME (If not institution, give street and number): St. Mary's Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Leonardtown	9c. COUNTY OF OEATH: St. Mary's	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: St. Mary's	10c. CITY, TOWN OR LOCATION: Mechanicsville	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1745 Bohle Road	10f. ZIP CODE: 20659	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR OATES: Korean War	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Maxican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4 or 5 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Fire Fighter	16b. KIND OF BUSINESS/INDUSTRY: U.S. Government	
17. FATHER'S NAME (First, Middle, Last): George Felix Spalding	18. MOTHER'S NAME (First, Middle, Maiden Surname): Louise Raley		
19a. INFORMANT'S NAME (Type/Print): Josephine Spalding	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1745 Bohle Rd., Mechanicsville, Maryland 20659		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland Veterans Cemetery DATE 6/28/1995	20c. LOCATION — City or Town, State: Cheltenham, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Michael L Gardiner	22. NAME AND ADDRESS OF FACILITY: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF):	days
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Carcinmatosis DUE TO (OR AS A CONSEQUENCE OF):	months
c.	Carcinma of Colon DUE TO (OR AS A CONSEQUENCE OF):	7yrs
d.		

PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO N.A.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEOICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF OEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. OATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. OESCRIBE HOW INJURY OCCUREO		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: J. Patrick Jarboe M.D.	29c. LICENSE NUMBER: D 0649	29d. DATE SIGNED (Month, Day, Year): 6-26-95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. PATRICK JARBOE, M.D. LEONARDTOWN, MARYLAND 20650		
31. DATE FILED (Month, Day, Year): JUN 27 1995	32. REGISTRAR'S SIGNATURE: Julia Blackistone Randall	

DHMH-18 Rev 1/89

(11)

95 20162

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ROBERT PHILIP STONE JR.			2. DATE OF DEATH (Month, Day, Year): JUNE 15, 1995	3. TIME OF DEATH: 7:30 P M
4. SOCIAL SECURITY NUMBER: 212-24-4989	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 66 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 2, 1929	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): St. Mary's Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Leonardtown		9c. COUNTY OF DEATH: St. Mary's

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: St. Mary's	10c. CITY, TOWN OR LOCATION: Hollywood	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Route 1 Box 380		10f. ZIP CODE: 20636	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Auto Mechanic	16b. KIND OF BUSINESS/INDUSTRY: U.S. Government	
17. FATHER'S NAME (First, Middle, Last): John David Stone		18. MOTHER'S NAME (First, Middle, Maiden Surname): Lucille Sophia Goldsborough	
19a. INFORMANT'S NAME (Type/Print): Wanda Mae Stone		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Route 1 Box 380, Hollywood, Maryland 20636	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Joy Chapel CEmetery DATE 6/19/1995	20c. LOCATION — City or Town, State: Hollywood, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michael K Gardiner		22. NAME AND ADDRESS OF FACILITY: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Respiratory Failure	24 hrs to 48 hrs
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. 2° to pneumonia and	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Lung Cancer	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Coronary Artery Disease

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: K Mehr	29c. LICENSE NUMBER: D36206	29d. DATE SIGNED (Month, Day, Year) ▶ 06/16/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Kiran D. Mehr MD Leonardtown MD 20650		
31. DATE FILED (Month, Day, Year): JUN 19 1995	32. REGISTRAR'S SIGNATURE: Julia Drucker-Randall	

OHMH-16 Rev 1/89

17

95 20163

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ernestine Anna Scheible
2. DATE OF DEATH — MONTH DAY YEAR: June 5, 1995
3. TIME OF DEATH: 5:15 a. M
4. SOCIAL SECURITY NUMBER: 578-01-7467
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 85 YRS. — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): Dec. 15, 1909
8. BIRTHPLACE (State or Foreign Country): Ohio
9a. FACILITY NAME (If not institution, give street and number): St. Mary's Nursing Center
9b. CITY, TOWN OR LOCATION OF DEATH: Leonardtown
9c. COUNTY OF DEATH: St. Mary's

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: St. Mary's
10c. CITY, TOWN OR LOCATION: Leonardtown
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Cedar Lane Apt. # 214
10f. ZIP CODE: 20650
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade — College (1-4 or 5+): 1 year
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary
16b. KIND OF BUSINESS/INDUSTRY: Law Firm
17. FATHER'S NAME (First, Middle, Last): Unknown
18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaretha P. Shaffer
19a. INFORMANT'S NAME (Type/Print): David M. Scheible
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4529 Three Notch Rd., Mechanicsville, Maryland 20659
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Trinity Episcopal Cemetery — DATE: 6/8/95
20c. LOCATION — City or Town, State: St. Mary's City, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Michael R. Gardiner
22. NAME AND ADDRESS OF FACILITY: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heert feilure. Liet only one ceuse on eech line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cerebrovascular accident	uks
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Dementia severe

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER: D19917
29d. DATE SIGNED (Month, Day, Year): 6/5/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. James C. Boyd, M.D. Leonardtown, Maryland 20650
31. DATE FILED (Month, Day, Year): JUN -6 1995
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

95 20164

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
George	William	Spence, Jr.	June 3, 1995	3:30 AM M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
216-14-0899	1 [X] M 2 [ ] F	83 YRS.			Dec 4, 1911	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
At Home, Rt. 238	Bushwood	St. Mary's

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	St. Mary's	Bushwood	1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
General Delivery	20618	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] YES 2 [X] NO	1 [ ] YES 2 [X] NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
10th Grade		Farmer	Farm

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
George William Spence	Elizabeth D. Einschutz

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Frances C. Spence	General Delivery Bushwood, Maryland 20618

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Sacred Heart Cemetery	6/6/95	Bushwood, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Michael L Gardiner	Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ACUTE MYOCARDIAL INFARCTION	2 HRS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	20 YRS
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [X] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [ ] YES 2 [X] NO	HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined		M	1 [ ] YES 2 [ ] NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Robert J Bauer, MD	D14168	▶ 6/5/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Robert J. Bauer, M.D. Mechanicsville, Maryland 20659

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN -6 1995	Julia Davidson-Randall

DHMH-16 Rev 1/89

AMENDED #1, 6-26-95, FS, WASH. Co. Health 95 20165

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) CATHERINE ~~OLEAN~~ OLEN TRESSLER		2. DATE OF DEATH (Month, Day, Year) JUNE 23 1995	3. TIME OF DEATH 07:05 AM
4. SOCIAL SECURITY NUMBER 216-14-6553	5. SEX 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday) 92 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year) 05/28/03
8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) RAVENWOOD NURSING CARE CENTER	9b. CITY, TOWN OR LOCATION OF DEATH HAGERSTOWN, MARYLAND	9c. COUNTY OF DEATH WASHINGTON	

RESIDENCE OF DECEDENT

10a. STATE Maryland	10b. COUNTY Washington	10c. CITY, TOWN OR LOCATION Hagerstown	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER 505½ Summit Avenue		10f. ZIP CODE 21740	10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 12; College (1-4 or 5+): 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Comptroller	16b. KIND OF BUSINESS/INDUSTRY Government
17. FATHER'S NAME (First, Middle, Last) James Roy Fisher		18. MOTHER'S NAME (First, Middle, Maiden Surname) Eva May Herbert	
19a. INFORMANT'S NAME (Type/Print) Betty T. Fish		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) HC73 Box 878A Locust Grove, Virginia 22508	
20a. METHOD OF DISPOSITION 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Hill Cemetery DATE 6-26-95	20c. LOCATION — City or Town, State Waynesboro, Pennsylvania	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ Scott Minnich	22. NAME AND ADDRESS OF FACILITY Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, euch es cardiec or reepiratory errest, shock, or heert feilure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel diseese or condition resulting in death) →	a. Pulmonary Edema	3 months
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initiated events resulting in death) LAST	b. Congestive Heart Failure	3 months
DUE TO (OR AS A CONSEQUENCE OF):	c. Mitral Insufficeincy	years
DUE TO (OR AS A CONSEQUENCE OF):	d. Rheumatic Heart Disease	years

PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I.

~~Hyertension~~
Recent Fracture of left hip (4/19/95) with surgical pinning

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	26a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY M
26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	26d. DESCRIBE HOW INJURY OCCURED	
26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER Edson B. Moody	29c. LICENSE NUMBER D07857	29d. DATE SIGNED (Month, Day, Year) ▶ 06/23/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Edson B. Moody, M.D. 1190 Mt. Aetna Rd. Hagerstown, Md. 21740		
31. DATE FILED (Month, Day, Year) JUN 26 1995	32. REGISTRAR'S SIGNATURE Julie Anderson Randall	

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 20166

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Donna Lee TURNER			2. DATE OF DEATH (Month, Day, Year): June 26, 1995	3. TIME OF DEATH: 12:15 PM
4. SOCIAL SECURITY NUMBER: 216-38-0274	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 54 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Oct.6,1940	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 11332 Crystal Falls Drive		9b. CITY, TOWN OR LOCATION OF DEATH: Smithsburg		9c. COUNTY OF DEATH: Washington
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Smithsburg		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 11332 Crystal Falls Drive		10f. ZIP CODE: 21783		10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+): 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): homemaker		16b. KIND OF BUSINESS/INDUSTRY: her own home
17. FATHER'S NAME (First, Middle, Last): Grayson Haupt		18. MOTHER'S NAME (First, Middle, Maiden Surname): Maxine Jones		
19a. INFORMANT'S NAME (Type/Print): John W. Turner		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11332 Crystal Falls Drive,Smithsburg,Md. 21783		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Bakersville Cemetery	DATE: 6-29-95	20c. LOCATION — City or Town, State: Bakersville,Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Scott M Minnich		22. NAME AND ADDRESS OF FACILITY: MINNICH FUNERAL HOME 415 E.Wilson Blvd.,Hagerstown,Md. 21740		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	ACUTE RESPIRATORY FAILURE	Hours
DUE TO (OR AS A CONSEQUENCE OF): b.	SQUAMOUS CELL CANCER IN LUNG	Months
DUE TO (OR AS A CONSEQUENCE OF): c.	SQUAMOUS CELL CANCER IN THROAT	1 YEAR
DUE TO (OR AS A CONSEQUENCE OF): d.	+ DEBIL.	

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☒ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Terminal Respiratory Failure R.L. Fugler, MD

29c. LICENSE NUMBER: D17067

29d. DATE SIGNED (Month, Day, Year): 6/27/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): STEPHEN E. METZNER, MD 747 NORTHERN AVE. HAGERSTOWN, MD

31. DATE FILED (Month, Day, Year): JUN 2 6 1995

32. REGISTRAR'S SIGNATURE: John Dutcher Randall

OHMH-16 Rev 1/89

95 20167

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Evaleen Thrasher			2. DATE OF DEATH (Month, Day, Year): June 17, 1995	3. TIME OF DEATH: 12:40AM M
4. SOCIAL SECURITY NUMBER: 218-30-0557	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 59 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Sep 5, 1935	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): 13 E. Indust. Blvd		9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland	9c. COUNTY OF DEATH: Allegany	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Cumberland	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 13 E. Industrial Blvd.		10f. ZIP CODE: 21502	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Charles Cook		18. MOTHER'S NAME (First, Middle, Maiden Surname): Maggie Mae (nmn)	
19a. INFORMANT'S NAME (Type/Print): Beverly C. Thrasher	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 311 Grand Avenue; Cumberland, MD 21502		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Biertown Cemetery DATE: 06/20	20c. LOCATION — City or Town, State: Rawlings, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James F Scarpelli	22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home Cumberland, MD 21502		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic heart disease	17 yrs
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Diabetes	17 yrs
DUE TO (OR AS A CONSEQUENCE OF):		
	c.	
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic smoker's bronchitis
Hypertension

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☒ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Dpty Med Ex	29c. LICENSE NUMBER: D 09157	29d. DATE SIGNED (Month, Day, Year): June 17, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Paul Snow, M.D. 124 w 3rd s tCumb MD 21502

31. DATE FILED (Month, Day, Year): JUN 20 1995	32. REGISTRAR'S SIGNATURE: Julia Thurlow-Kendall

DHMH-16 Rev 1/99

95 20168

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EVELYN VIRGINIA TROXELL			2. DATE OF DEATH (Month, Day, Year): June 17, 1995	3. TIME OF DEATH: 4:15 a M
4. SOCIAL SECURITY NUMBER: 214-16-2739	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 84 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): JULY 4 1910	8. BIRTHPLACE (State or Foreign Country): PA.
9a. FACILITY NAME (If not institution, give street and number): MEMORIAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND		9c. COUNTY OF DEATH: ALLEGANY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: ALLEGANY	10c. CITY, TOWN OR LOCATION: CUMBERLAND	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 229 BALTIMORE AVE		10f. ZIP CODE: 21502	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+):	18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSE KEEPER	18b. KIND OF BUSINESS/INDUSTRY: HOUSE KEEPER	
17. FATHER'S NAME (First, Middle, Last): ELMER RUSSELL		16. MOTHER'S NAME (First, Middle, Maiden Surname): CARRIE STONER	
19a. INFORMANT'S NAME (Type/Print): DALE MERRITT	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 404 DECATUR STREET CUMBERLAND MARYLAND 21502		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): ROSE HILL CEMETERY DATE: JUNE 19 1995	20c. LOCATION — City or Town, State: CUMBERLAND MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dale L. Merritt	22. NAME AND ADDRESS OF FACILITY: MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory Failure	12 hours
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Aspiration Pneumonia	7 days
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Vomiting Post Surgery	12 days
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. Gastric Outlet Obstruction	3 months

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29e. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D 34999	29d. DATE SIGNED (Month, Day, Year): June 18-1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Sheilesh Adeshara-Johnson Heights Medical Building-Cumberland, MD 21502		
31. DATE FILED (Month, Day, Year): JUN 19 1995	32. REGISTRAR'S SIGNATURE	

DHMH-18 Rev 1/89

95 20169

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Catherine B. Twigg
2. DATE OF DEATH (Month, Day, Year): June 19, 1995
3. TIME OF DEATH: 10:50 P M
4. SOCIAL SECURITY NUMBER: 429-50-7238
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 62 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): Aug. 28, 1932
8. BIRTHPLACE (State or Foreign Country): Arkansas
9a. FACILITY NAME (If not institution, give street and number): 7916 Helmart Drive
9b. CITY, TOWN OR LOCATION OF DEATH: Laurel
9c. COUNTY OF DEATH: Howard

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Howard
10c. CITY, TOWN OR LOCATION: Laurel
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 7916 Helmart Drive
10f. ZIP CODE: 20723
10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Office Manager
16b. KIND OF BUSINESS/INDUSTRY: Contracting
17. FATHER'S NAME (First, Middle, Last): Orin Knabe
18. MOTHER'S NAME (First, Middle, Maiden Surname): Grace (Unavailable)
19a. INFORMANT'S NAME (Type/Print): Mona Jones
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1726 Peppermint Lane, Westminster, MD 21157
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Walnut Grove Cemetery | DATE: 6-23
20c. LOCATION — City or Town, State: Little Rock, Arkansas
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ellen H. Rapp
22. NAME AND ADDRESS OF FACILITY: Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. GLIOSARCOMA (INTRACRANIAL) — 4 months
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Patryce A. Toye, M.D. Deputy ME Howard County
29c. LICENSE NUMBER: D31473
29d. DATE SIGNED (Month, Day, Year): ▶ June 20, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Patryce A. Toye, M. D., 5755 Cedar Lane, Columbia, MD 21044
31. DATE FILED (Month, Day, Year): JUN 21 1995
32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

OHMH-16 Rev 1/89

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95 20170

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Anthony K. Terry			2. DATE OF DEATH (Month, Day, Year): June 14, 1995	3. TIME OF DEATH: 8:20 p. M
4. SOCIAL SECURITY NUMBER	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 27 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Dec. 6, 1967	8. BIRTHPLACE (State or Foreign Country): New York
9a. FACILITY NAME (If not institution, give street and number): 2915 Aquarius Ave.		9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring		9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Silver Spring	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO
10e. STREET AND NUMBER: 2915 Aquarius Ave.		10f. ZIP CODE: 20906	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 5+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Doctor	16b. KIND OF BUSINESS/INDUSTRY: Georgetown Hospital
17. FATHER'S NAME (First, Middle, Last): Hubert Terry		18. MOTHER'S NAME (First, Middle, Maiden Surname): Myran Parmley	
19a. INFORMANT'S NAME (Type/Print): Hubert Terry (Father)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2915 Aquarius Ave., SilverSpring, MD 20906	

20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Westview Cemetery	DATE: 6/21	20c. LOCATION — City or Town, State: Upperville, VA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: George R. Snowden		22. NAME AND ADDRESS OF FACILITY: SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

29. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory Syndrome	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Encephalitis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. GASTRO Enteritis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. HIV POSITIVE — AIDS	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Acquired Immune Deficiency

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 X Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TYPE OF CERTIFIER: Mark R Abbruzzese MD	29c. LICENSE NUMBER: 15748 DC	29d. DATE SIGNED (Month, Day, Year): ▶ 6/19/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARK R. ABBRUZZESE MD 4910 MASSACHUSETTS AVE NW #304 WASHINGTON DC 20016		
31. DATE FILED (Month, Day, Year): JUN 20 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall	

DHMH-16 Rev 1/89

4

95-3528-033
B.K.S

95 20171

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOSEPH ELLWOOD TAYLOR			2. DATE OF DEATH (Month, Day, Year): JUNE 15, 1995	3. TIME OF DEATH: 6:00 P M
4. SOCIAL SECURITY NUMBER: 220-16-8563	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 67 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): August 7, 1927	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): PRINCE GEORGES HOSPITAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: CHEVERLY		9c. COUNTY OF DEATH: PRINCE GEORGES

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: St. Mary's	10c. CITY, TOWN OR LOCATION: Scotland	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: General Delivery		10f. ZIP CODE: 20687	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Waterman	16b. KIND OF BUSINESS/INDUSTRY: Domestic Fishing	
17. FATHER'S NAME (First, Middle, Last): J. Frank Taylor		18. MOTHER'S NAME (First, Middle, Maiden Surname): Viola Smith	
19a. INFORMANT'S NAME (Type/Print): Ida R. Taylor		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): General Delivery, Scotland, Maryland 20687	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): St. Peter Claver; DATE: 6/20/95	20c. LOCATION — City or Town, State: St. Inigoes, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Edward N. Brinsfield, Jr. M00052		22. NAME AND ADDRESS OF FACILITY: Brinsfield Funeral Home P.O. Box 279, Leonardtown, Maryland 20650	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Multiple Injuries	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: XX 1 [ ] Inpatient 2 ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 6-15-95	28b. TIME OF INJURY: 1545 M	28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO	28d. DESCRIBE HOW INJURY OCCURED: motor vehicle collision
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): street			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Md Rt 5 St Marys Co. Md

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Dennis J. Chute MD	29c. LICENSE NUMBER: O.C.M.E	29d. DATE SIGNED (Month, Day, Year): ▶ JUNE 16, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DENNIS CHUTE M.D. 111 Penn Street, Baltimore, Maryland 21201		
31. DATE FILED (Month, Day, Year): JUN 20 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

Amended #3/ 6/19/95 MRT Montgomery County

95 20172

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Rafael H. Usera, Sr.				2. DATE OF DEATH (Month, Day, Year): June 15, 1995	3. TIME OF DEATH: 11:07 A. M
4. SOCIAL SECURITY NUMBER: 581-07-1242	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 75 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): July 13, 1919
8. BIRTHPLACE (State or Foreign Country): Puerto Rico					
9a. FACILITY NAME (If not institution, give street and number): Washington Adventist Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Takoma Park		9c. COUNTY OF DEATH: Montgomery	
RESIDENCE OF DECEDENT					
10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Silver Spring		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO	
10e. STREET AND NUMBER: 8303 12th Ave.		10f. ZIP CODE: 20903		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [X] YES 2 [ ] NO Specify: Puerto Rican		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): tailor	16b. KIND OF BUSINESS/INDUSTRY: mens clothing			
17. FATHER'S NAME (First, Middle, Last): Hipolito Usera		18. MOTHER'S NAME (First, Middle, Maiden Surname): Francesca Cortada			
19a. INFORMANT'S NAME (Type/Print): Rafael H. Usera, Jr.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8303 12th Ave. Silver Spring, MD 20903			
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitian Cematory June	DATE: 20, 1995	20c. LOCATION — City or Town, State: Alexandria, VA		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dana A Meebach		22. NAME AND ADDRESS OF FACILITY: Takoma Funeral Home, Inc. 254 Carroll St. NW Washington, D.C. 20012			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. RESPIRATORY FAILURE	24 HR
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. PNEUMONIA	24 HR
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. CHRONIC OBSTRUCTIVE LUNG DISEASE	20 YRS
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. CIGARETE SMOKING	60 YRS

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [X] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Ernesto Africano M.D.	D-19400	▶ 6-15-95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
ERNESTO AFRICANO, M.D. 831 UNIVERSITY BLVD SILVER SPRING, MD

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
6-15-95	JUN 19 1995 Julie Strickler Randall

DHMH-16 Rev 1/89

95 20173

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CORA LILLIAN VONTRESS			2. DATE OF DEATH (Month, Day, Year): June 15, 1995	3. TIME OF DEATH: 7:55 A M
4. SOCIAL SECURITY NUMBER: 405-32-6683	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): July 2, 1916	8. BIRTHPLACE (State or Foreign Country): Kentucky
9a. FACILITY NAME (If not institution, give street and number): Montgomery General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Olney		9c. COUNTY OF DEATH: Montgomery
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Silver Spring		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3812 Bel Pre Road, #9		10f. ZIP CODE: 20906		10g. CITIZEN OF WHAT COUNTRY? United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Nurse LPN		16b. KIND OF BUSINESS/INDUSTRY: Hospital
17. FATHER'S NAME (First, Middle, Last): Woodford Christian		18. MOTHER'S NAME (First, Middle, Maiden Surname): Sarah Clay		
19a. INFORMANT'S NAME (Type/Print): Gregory Vontress		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3812 Bel Pre Road, #9, Silver Spring, MD 20906		
20a. METHOD OF DISPOSITION: XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Dayton National Cemetery	DATE: 6-21	20c. LOCATION — City or Town, State: Dayton, Ohio	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ellen L. Rapp		22. NAME AND ADDRESS OF FACILITY: Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. SEPSIS	DAYS.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. METASTATIC BREAST CANCER	MONTHS.
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: dementia, Coronary artery disease.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☑ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

28. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD

29c. LICENSE NUMBER: A D38457

29d. DATE SIGNED (Month, Day, Year): ▶ 6-15-95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): N. GOMACUD 18111 PRINCE PHILIP DR, OLNEY MD 20832

31. DATE FILED (Month, Day, Year): JUN 19 1995

32. REGISTRAR'S SIGNATURE: Jean Woodall

DHMH-16 Rev 1/89

3

95 20174

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Kenneth Bryan WOLFENSBERGER		2. DATE OF DEATH (Month, Day, Year): June 23 1995	3. TIME OF DEATH: 0230 M
4. SOCIAL SECURITY NUMBER: 215-26-9135	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 65 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Sept. 24 1929
8. BIRTHPLACE (State or Foreign Country): Maryland			
9a. FACILITY NAME (If not institution, give street and number): 16733 National Pike	9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown	9c. COUNTY OF DEATH: Washington	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Hagerstown	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 16733 National Pike	10f. ZIP CODE: 21740	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10	College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): laborer	16b. KIND OF BUSINESS/INDUSTRY: Electrical Supply
17. FATHER'S NAME (First, Middle, Last): William Bryan Wolfensberger		18. MOTHER'S NAME (First, Middle, Maiden Surname): Elsie Brewer	
19a. INFORMANT'S NAME (Type/Print): Dorothy Wolfensberger		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 16733 National Pike Hagerstown, Md. 21740	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Hagerstown Crematory DATE 6-23-95		20c. LOCATION — City or Town, State: Hagerstown, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Scott M Minnich		22. NAME AND ADDRESS OF FACILITY: Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or reapiratory arrest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Lung Cancer	2 months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Michael J. McCormack M.D.	29c. LICENSE NUMBER: 041667	29d. DATE SIGNED (Month, Day, Year): ▶ 6-23-95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Michael J. McCormack 1799 Howell Rd. Hagerstown, MD 21740		
31. DATE FILED (Month, Day, Year): JUN 26 1995	32. REGISTRAR'S SIGNATURE: Jbi	

DHMH-16 Rev 1/89

95 20175

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Arthur Joseph WILLIAMS, Jr.			2. DATE OF DEATH (Month, Day, Year): June 22 95	3. TIME OF DEATH: 9:31 P M
4. SOCIAL SECURITY NUMBER: 579-20-6810	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 71 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): April 29, 1924	8. BIRTHPLACE (State or Foreign Country): Washington D.C.
9a. FACILITY NAME (If not institution, give street and number): Washington County Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown		9c. COUNTY OF DEATH: Washington

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Myersville	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 2223 Michael Road		10f. ZIP CODE: 21773	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: W.W. II	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Manufacturer's Rep.	16b. KIND OF BUSINESS/INDUSTRY: Food Service
17. FATHER'S NAME (First, Middle, Last): Arthur Joseph Williams		18. MOTHER'S NAME (First, Middle, Maiden Surname): Rita Faye Skiles	
19a. INFORMANT'S NAME (Type/Print): Bettye B. Williams		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2223 Michael Road Myersville, Md. 21773	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place): Hagerstown Crematory 6-24-95 DATE	20c. LOCATION — City or Town, State: Hagerstown, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Fred LeMasters		22. NAME AND ADDRESS OF FACILITY: Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Myelogenous leukemia	1 month
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Stephen Lippman, MD	29c. LICENSE NUMBER: D35547	29d. DATE SIGNED (Month, Day, Year) ▶ 6/22/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): S. Lippman, 11110 Medical Campus Rd. Hag. Md. 21740		
31. DATE FILED (Month, Day, Year): JUN 26 1995	32. REGISTRAR'S SIGNATURE: Julie Lawson Marshall	

DHMH-16 Rev 1/89

95 20176

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARSHALL F. WILLISON				2. DATE OF DEATH (Month, Day, Year): June 22, 1995	3. TIME OF DEATH: 12:42 A M
4. SOCIAL SECURITY NUMBER: 214-05-8396	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 80 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Oct 27, 1914	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital & Medical Center			9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland		9c. COUNTY OF DEATH: Allegany

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Cumberland	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 912 Piedmont Avenue		10f. ZIP CODE: 21502	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO; IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Retired electrician	16b. KIND OF BUSINESS/INDUSTRY: B & O Railroad	
17. FATHER'S NAME (First, Middle, Last): Marshall Willison		18. MOTHER'S NAME (First, Middle, Maiden Surname): Leda (Freeland)	
19a. INFORMANT'S NAME (Type/Print): Lillian R. Willison		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 912 Piedmont Avenue; Cumberland, MD 21502	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place): Maryland Veterans Cemetery; DATE: 06/26	20c. LOCATION — City or Town, State: Flintstone, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James F. Scarpelli		22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home Cumberland, MD 21502	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complicetione thet caused the death. Do not enter the mode of dying, such as cerdiac or reepiretory arrest, shock, or haert failure. Liet only one ceuse on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition resulting in death) →	a. Carcinoma of lung	2 years
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

Chronic obstructive pulmonary disease

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [X] NO [ ] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D 33280	29d. DATE SIGNED (Month, Day, Year): ▶ June 22, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. S. Gupta Johnson Heights Medical Building Cumberland, MD. 21502		
31. DATE FILED (Month, Day, Year): JUN 23 1995	32. REGISTRAR'S SIGNATURE	

OHMH-18 Rev 1/89

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95 20177

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): THOMAS GEORGE WOTRING			2. DATE OF DEATH (Month, Day, Year): JUNE 7 1995	3. TIME OF DEATH: 5:15P M
4. SOCIAL SECURITY NUMBER: 219-74-6156	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 39 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): FEBRUARY 17 1956	8. BIRTHPLACE (State or Foreign Country): PENNSYLVANIA
9a. FACILITY NAME (If not institution, give street and number): 13016 MALLARD STREET		9b. CITY, TOWN OR LOCATION OF DEATH: BOWLING GREEN	9c. COUNTY OF DEATH: ALLEGANY	
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: ALLEGANY	10c. CITY, TOWN OR LOCATION: BOWLING GREEN	10d. INS/OE CITY LIMITS? 1 [X] YES 2 [ ] NO	
10e. STREET AND NUMBER: 13016 MALLARD STREET		10f. ZIP CODE: 21502	10g. CITIZEN OF WHAT COUNTRY? U S A	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): 5+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): OWNER/OPERATOR	16b. KIND OF BUSINESS/INDUSTRY: FLORAL BUSINESS		
17. FATHER'S NAME (First, Middle, Last): PETE WOTRING		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARTHA NIEDERRITER		
19a. INFORMANT'S NAME (Type/Print): CINDY H. WOTRING		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13016 MALLARD STREET BOWLING GREEN, MD 21502		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): RESTLAWN MEMORIAL GARD. DATE: 6/12	20c. LOCATION — City or Town, State: LAVALE, MD		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Douglas A Hafer	22. NAME AND ADDRESS OF FACILITY: HAFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY LAVALE, MD 21502			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Primitive Neuroectodermal tumor	Feb 94
DUE TO (OR AS A CONSEQUENCE OF):	Advanced.	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
DUE TO (OR AS A CONSEQUENCE OF):		
	c.	
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [✓] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [✓] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [✓] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one): 1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Jam MD	D23371	June 12, 95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): QAMAR ZAMAN M.D. 625 KENT AVE. CUMBERLAND, MD 21502

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 13 1995	Julia Davidson-Randall

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DHMH-16 Rev 1/89

95 20178

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Jeanette A. Wootten
2. DATE OF DEATH (Month, Day, Year): June 21, 1995
3. TIME OF DEATH: 10:45 PM
4. SOCIAL SECURITY NUMBER: 577-01-2843
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 78 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): AUG. 24, 1916
8. BIRTHPLACE (State or Foreign Country): WASH. D.C.
9a. FACILITY NAME (If not institution, give street and number): MONTGOMERY GENERAL HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: OLNEY
9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE: PA.
10b. COUNTY: SNYDER
10c. CITY, TOWN OR LOCATION: MIDDLEBURG
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: RD 1 BOX 180
10f. ZIP CODE: 17842
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER
16b. KIND OF BUSINESS/INDUSTRY: AT HOME
17. FATHER'S NAME (First, Middle, Last): WILLIAM JOHN DOOLAN
18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY MAUDE CROOK
19a. INFORMANT'S NAME (Type/Print): KARLEEN W. ZABASKY
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2301 SEIBEL DR., SILVER SPRING, MD. 20905
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): CHAMBERS CREMATORY | DATE: 6/23
20c. LOCATION — City or Town, State: RIVERDALE, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: W.W. Chambers | M00091
22. NAME AND ADDRESS OF FACILITY: W. W. CHAMBERS CO. INC., SILVER SPRING, MD. 20910

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Colon Cancer	Four Months
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. DUE TO (OR AS A CONSEQUENCE OF):		
c. DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. LICENSE NUMBER: D33686
29d. DATE SIGNED (Month, Day, Year): June 22 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Kenneth Miller MD 18111 Prince Philip Dr. Olney, MD 20832

31. DATE FILED (Month, Day, Year): JUN 23 1995
32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall

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DHMH-16 Rev 1/89

95 20179

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DONALD LOUIS WASSMANN			2. DATE OF DEATH (Month, Day, Year): June 17, 1995	3. TIME OF DEATH: 947 P M
4. SOCIAL SECURITY NUMBER: 579-54-2703	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 51 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): APR 4, 1944	8. BIRTHPLACE (State or Foreign Country): Washington, D.C.
9a. FACILITY NAME (If not institution, give street and number): Howard County General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Columbia	9c. COUNTY OF DEATH: Howard	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Howard	10c. CITY, TOWN OR LOCATION: Laurel	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 10609 Johns Hopkins Road		10f. ZIP CODE: 20723	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 2	16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Steam Fitter	16b. KIND OF BUSINESS/INDUSTRY: Federal Government
17. FATHER'S NAME (First, Middle, Last): Alvin Gustav Wassmann		18. MOTHER'S NAME (First, Middle, Maiden Surname): Minnie Mae Phaup	
19a. INFORMANT'S NAME (Type/Print): Geraldine Wassmann		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10609 Johns Hopkins Road Laurel, Maryland 20723	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland National Park DATE 6/21/95	20c. LOCATION — City or Town, State: Laurel, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James E. Dooley		22. NAME AND ADDRESS OF FACILITY: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or raspiratory arreat, shock, or heert feilure. List only one ceuse on eech line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition resulting in death) → a.	Malignant Ventricular Arrhythmia - Sudden Death	secs
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Acute Myocardial Ischemia	mins
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Atherosclerotic Cardiovascular Disease	years
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.: Rheumatoid arthritis

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA. OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Patrick A. Tote, MD Deputy ME Howard County		29c. LICENSE NUMBER: D31473	29d. DATE SIGNED (Month, Day, Year): June 18, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PATRICK A. TOTE, MD 4565 ITEM LOCK ONE WAY ELLICOTT CITY MD 21042			
31. DATE FILED (Month, Day, Year): JUN 21 1995	32. REGISTRAR'S SIGNATURE: Julie Davidson Corbett		

DHMH-16 Rev 1/89

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95 20180

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Pauline Wolfe			2. DATE OF DEATH (Month, Day, Year): JUNE 18, 1995	3. TIME OF DEATH: 7:20 AM M
4. SOCIAL SECURITY NUMBER: 067-10-5687	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 99 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): MAY 16, 1896	8. BIRTHPLACE (State or Foreign Country): MASSACHUSETTS
9a. FACILITY NAME (If not institution, give street and number): HEBREW HOME OF GREATER WASHINGTON		9b. CITY, TOWN OR LOCATION OF DEATH: ROCKVILLE		9c. COUNTY OF DEATH: MONTGOMERY
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: ROCKVILLE		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 6121 MONTROSE ROAD		10f. ZIP CODE: 20852		10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER	16b. KIND OF BUSINESS/INDUSTRY: OWN HOME		
17. FATHER'S NAME (First, Middle, Last): CHARLES LEVY		18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNIE JAFFEE		
19a. INFORMANT'S NAME (Type/Print): DOROTHY KULIK (DAUGHTER)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12105 LITTLE CREEK DRIVE - POTOMAC, MARYLAND 20854		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): HAR MORIAH	DATE: 6/20	20c. LOCATION — City or Town, State: BOSTON, MASSACHUSETTS	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert Thomas		22. NAME AND ADDRESS OF FACILITY: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MARYLAND 20852		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory Failure	Immediate
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Pulmonary Edema	Immediate
DUE TO (OR AS A CONSEQUENCE OF):		
	c. Coronary Artery Disease	Long - Standing
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Michael Krafty MD	D21935	▶ June 18 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Michael Krafty 2101 Medical Park Dr Silver Spring, MD 20902

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 20 1995	Julie Davidson Rockett

DHMH-16 Rev 1/89

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95 20181

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Richard White Jr.			2. DATE OF DEATH (Month, Day, Year): June 12, 1995	3. TIME OF DEATH: 12:45 PM
4. SOCIAL SECURITY NUMBER: 154-05-5043-A	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 19, 1917	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Bayside Nursing Center		9b. CITY, TOWN OR LOCATION OF DEATH: Lexington Park		9c. COUNTY OF DEATH: St. Mary's
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: St. Mary's	10c. CITY, TOWN OR LOCATION: Park Hall		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: P.O. Box 262		10f. ZIP CODE: 20667		10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Sheet Metal Worker		16b. KIND OF BUSINESS/INDUSTRY: U.S. Navy/Defense
17. FATHER'S NAME (First, Middle, Last): Richard White, Sr.			18. MOTHER'S NAME (First, Middle, Maiden Surname): Alice Shorter	
19a. INFORMANT'S NAME (Type/Print): Rose White		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 262, Park Hall, Maryland 20667		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): St. Lukes Cemetery DATE: 6/17/95		20c. LOCATION — City or Town, State: Scotland, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Michael K. Blankenship		22. NAME AND ADDRESS OF FACILITY: Brinsfield Funeral Home, P.O. Box 279, Leonardtown, Maryland 20650		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or reepiratory arrest, ehock, or heert feilure. Liet only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition resulting in death) → a.	Respiratory Failure -	1-2 hours -
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially liat conditiona, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury that initiated events resulting in death) LAST — b.	cardiomyopathy, c	2-3 years -
DUE TO (OR AS A CONSEQUENCE OF):		
c.	congestive Heart failure -	
DUE TO (OR AS A CONSEQUENCE OF):		
d.	Renal failure.	2 years -

PART II. Othar significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

28. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Rita B. Jhaveri M.D.	M25268	▶ 6/13/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Rita B. Jhaveri, M.D. 100 Exploration II, Lexington Park, Maryland 20653

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 13 1995	Julia Davidson-Randall

DHMH-18 Rev 1/89

(4)

95 20182

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LINDA B. YOST			2. DATE OF DEATH (Month, Day, Year): June 14, 1995	3. TIME OF DEATH: 9:03 A M
4. SOCIAL SECURITY NUMBER: 235-70-3139	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 50 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): DECEMBER 7 1944	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland		9c. COUNTY OF DEATH: Allegany

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: ALLEGANY	10c. CITY, TOWN OR LOCATION: CUMBERLAND	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 420 BEALL STREET		10f. ZIP CODE: 21502	10g. CITIZEN OF WHAT COUNTRY?: U S A

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): OWNER/OPERATOR	16b. KIND OF BUSINESS/INDUSTRY: HAIR SALON	
17. FATHER'S NAME (First, Middle, Last): DOUGLAS DEFFINBAUGH		18. MOTHER'S NAME (First, Middle, Maiden Surname): ANEDA NOLAND	
19a. INFORMANT'S NAME (Type/Print): ROBERT A. YOST		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 420 BEALL STREET CUMBERLAND, MD 21502	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): SUNSET MEMORIAL PARK DATE: 6/16	20c. LOCATION — City or Town, State: CUMBERLAND, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Douglas A Hafer	22. NAME AND ADDRESS OF FACILITY: HAFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY LAVALE, MD 21502		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ADVANCED BILATERAL BREAST CARINOMA	JULY 1994
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD,	29c. LICENSE NUMBER: D 23371	29d. DATE SIGNED (Month, Day, Year): ▶ June 15, 95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Qamar Zaman, M.D., Suite 102, 625 Kent Ave., Cumberland, Md. 21502		
31. DATE FILED (Month, Day, Year): JUN 16 1995	32. REGISTRAR'S SIGNATURE: [illegible] Randall	

3

DHMH-16 Rev 1/89

95 20183

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Robert Lewis Andrews			2. DATE OF DEATH — MONTH: 06 DAY: 09 YEAR: 95	3. TIME OF DEATH: 1:15 a M
4. SOCIAL SECURITY NUMBER: 213-52-7991	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 45 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): August 8, 1949	8. BIRTHPLACE (State or Foreign Country): Delaware
9a. FACILITY NAME (If not institution, give street and number): 220 Shamrock Lane		9b. CITY, TOWN OR LOCATION OF DEATH: Elkton		9c. COUNTY OF DEATH: Cecil

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Cecil	10c. CITY, TOWN OR LOCATION: Elkton	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 220 Shamrock Lane		10f. ZIP CODE: 21921	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: Vietnam	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Parts Painter	16b. KIND OF BUSINESS/INDUSTRY: Unknown	
17. FATHER'S NAME (First, Middle, Last): George Robert Andrews		18. MOTHER'S NAME (First, Middle, Maiden Surname): Louise Carey	
19a. INFORMANT'S NAME (Type/Print): Edward T. Andrews		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 220 Shamrock Lane, Elkton, MD 21921	

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): North East Methodist Cem.	DATE: 6/13	20c. LOCATION — City or Town, State: North East, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: Crouch Funeral Home, 127 South Main Street, North East, MD 21901		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acquired Immune Deficiency Disease	2 - 4 Years
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ ND	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Robert L. Gray	29c. LICENSE NUMBER: D-01858	29d. DATE SIGNED (Month, Day, Year): June 13, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Robert L. Gray, 221 E. Main Street, Elkton, MD 21921

31. DATE FILED (Month, Day, Year): JUN 14 1995	32. REGISTRAR'S SIGNATURE: Julia Thurston-Randall

DHMH-16 Rev 1/89

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95 20184

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Olive May ARCHER		2. DATE OF DEATH (Month, Day, Year): June 18, 1995	3. TIME OF DEATH: 10:15 A. M
4. SOCIAL SECURITY NUMBER: 181-32-4855	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 84 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Jan. 19, 1911
8. BIRTHPLACE (State or Foreign Country): Pennsylvania			
9a. FACILITY NAME (If not institution, give street and number): Homewood Retirement	9b. CITY, TOWN OR LOCATION OF DEATH: Frederick	9c. COUNTY OF DEATH: Frederick	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Frederick	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 31 West Patrick Street	10f. ZIP CODE: 21701	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12):	College (1-4 or 5+): 5	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Social worker	16b. KIND OF BUSINESS/INDUSTRY: State Government
17. FATHER'S NAME (First, Middle, Last): Benjamin Franklin Archer		18. MOTHER'S NAME (First, Middle, Maiden Surname): Millie McClain	
19a. INFORMANT'S NAME (Type/Print): Dr. James Walker Carty, Jr.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 661 South Atlantic Ave., Virginia Beach, Va. 23451	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Smithsburg Crematory DATE: June 19, 1995	20c. LOCATION — City or Town, State: Smithsburg, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Richard C.C. Basford M00021		22. NAME AND ADDRESS OF FACILITY: Keeney and Basford Funeral Home 106 East Church Street, Frederick, Md. 21701	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Congestive Heart Failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Aortic Stenosis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☑ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: James E Beales MD	29c. LICENSE NUMBER: D30456	29d. DATE SIGNED (Month, Day, Year): ▶ 6/15/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 300 W. 6th St. Frederick, Md. 21701 Dr. Francis Becker, M.D.		
31. DATE FILED (Month, Day, Year): JUN 19 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

95 20185

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): John Vincent ATANASOFF			2. DATE OF DEATH (Month, Day, Year): June 15, 1995	3. TIME OF DEATH: 9:40 pm M
4. SOCIAL SECURITY NUMBER: 577-48-3789	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 91 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Oct 4, 1903	8. BIRTHPLACE (State or Foreign Country): New York
9a. FACILITY NAME (If not institution, give street and number): 11928 East Baldwin Road		9b. CITY, TOWN OR LOCATION OF DEATH: Monrovia		9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Monrovia	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 11928 East Baldwin Road		10f. ZIP CODE: 21770	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 5+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Professor/Inventor	16b. KIND OF BUSINESS/INDUSTRY: Physics/Mathematics
17. FATHER'S NAME (First, Middle, Last): John ATANASOFF		18. MOTHER'S NAME (First, Middle, Maiden Surname): Iva PURDY	
19a. INFORMANT'S NAME (Type/Print): Mrs. Alice C. Atanasoff		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11928 E Baldwin Road, Monrovia, Maryland 21770	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Smithsburg Crematory DATE: Jun 16,1995	20c. LOCATION — City or Town, State: Smithsburg,Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Keith Lyman Roberson M00706		22. NAME AND ADDRESS OF FACILITY: Keeney & Basford P.A. Funeral Home 106 E Church Street, Frederick, MD 21701	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CVA. — Recent. DUE TO (OR AS A CONSEQUENCE OF):	2yr.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	26e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28l. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: R Kaufmann	29c. LICENSE NUMBER: D13971	29d. DATE SIGNED (Month, Day, Year): ▶ June 16, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Robert L. Kaufmann, M.D., 300 West Ninth Street, Frederick, Maryland 21701

31. DATE FILED (Month, Day, Year): JUN 19 1995	32. REGISTRAR'S SIGNATURE: Julia Dawson Randall

DHMH-16 Rev 1/89

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ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-725 7/24/95 t.t

95 20186

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): John Franklin Adams, Jr. (John Adams, Jr.)
2. DATE OF DEATH (Month, Day, Year): June 19 1995
3. TIME OF DEATH: 2055 M
4. SOCIAL SECURITY NUMBER: 215-38-5501
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 56 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Dec. 17, 1938
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Howard County General Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Columbia
9c. COUNTY OF DEATH: Howard

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Howard
10c. CITY, TOWN OR LOCATION: Elkridge
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 102 Saint Jean Way
10f. ZIP CODE: 21227
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Printer
16b. KIND OF BUSINESS/INDUSTRY: U.S. Government
17. FATHER'S NAME (First, Middle, Last): John Franklin Adams, Sr.
18. MOTHER'S NAME (First, Middle, Maiden Surname): Agatha Hope Thompson
19a. INFORMANT'S NAME (Type/Print): Lisa A. Fenton
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7919 Mayfield Avenue, Elkridge, Maryland 21227
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): St. John's Cemetery DATE June 23,1995
20c. LOCATION — City or Town, State: Hollywood, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Michael K Gardiner
22. NAME AND ADDRESS OF FACILITY: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CARCINOMA OF THE LUNG COMPLICATED BY HEMORRHAGE	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year): 6/19/95
28b. TIME OF INJURY: 5:30 P M
28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO
28d. DESCRIBE HOW INJURY OCCURED: POST OPERATIVE HEMORRHAGE
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): CORONARY CARE UNIT
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): HOWARD COUNTY GENERAL HOSPITAL

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER:
29c. LICENSE NUMBER: O.C.M.E.
29d. DATE SIGNED (Month, Day, Year): June 20 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201
31. DATE FILED (Month, Day, Year): JUN 28 1995
32. REGISTRAR'S SIGNATURE: Julia Theodora Randall

DHMH-18 Rev 1/89

95 20187

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Richard H. Bohm			2. DATE OF DEATH (Month, Day, Year): June 13 1995	3. TIME OF DEATH: 9:40 PM M
4. SOCIAL SECURITY NUMBER: 396 14 8207	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (If yrs. last birthday): 71 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Feb. 24, 1924	8. BIRTHPLACE (State or Foreign Country): Chicago, Il.
9a. FACILITY NAME (If not institution, give street and number): 960 Stable Court		9b. CITY, TOWN OR LOCATION OF DEATH: Davidsonville	9c. COUNTY OF DEATH: Anne Arundel	
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Davidsonville	10d. INSIDE CITY LIMITS? 1 ☐ YES ☒ NO	
10e. STREET AND NUMBER: 960 Stable Court		10f. ZIP CODE: 21035	10g. CITIZEN OF WHAT COUNTRY?: United States	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: Yes 44-66	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: No	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Communications	16b. KIND OF BUSINESS/INDUSTRY: U.S.A.F.		
17. FATHER'S NAME (First, Middle, Last): Joseph F. Bohm		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ethel Graca		
19a. INFORMANT'S NAME (Type/Print): Etta Bohm		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 960 Stable Court Davidsonville Md. 21035		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland Veterans Cemetery DATE: 6/16/95	20c. LOCATION — City or Town, State: Cheltenham, Md.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert E. Evans Pres		22. NAME AND ADDRESS OF FACILITY: Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. malignant parietal meningioma	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Robert Scott Eden, MD	29c. LICENSE NUMBER: D30701	29d. DATE SIGNED (Month, Day, Year) ▶ 06/14/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Robert Scott Eden 600 Ridgely Ave. Annapolis Md.

31. DATE FILED (Month, Day, Year): JUN 16 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

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1 of 2

95 20188

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 0/3

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ROSALIE (AKA ROSA LEE) (AKA ROSE LEE) BARTLEY
2. DATE OF DEATH — MONTH DAY YEAR: JUNE 12, 1995
3. TIME OF DEATH: 10:00 P.M
4. SOCIAL SECURITY NUMBER: 578-34-5296
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 96 YRS. — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): AUG 19, 1898
8. BIRTHPLACE (State or Foreign Country): Ft. Motte,S.C.
9a. FACILITY NAME (If not institution, give street and number): CARROLL MANOR NURSING HOME
9b. CITY, TOWN OR LOCATION OF DEATH: HYATTSVILLE
9c. COUNTY OF DEATH: PRINCE GEORGES

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: PRINCE GEORGES
10c. CITY, TOWN OR LOCATION: LANHAM
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 4530 KINMOUNT ROAD
10f. ZIP CODE: 20706
10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): COOK
16b. KIND OF BUSINESS/INDUSTRY: BAKERY
17. FATHER'S NAME (First, Middle, Last): EDMUND BARTLEY
18. MOTHER'S NAME (First, Middle, Maiden Surname): CECELIA GLOVER
19a. INFORMANT'S NAME (Type/Print): PATRICIA FRANCIS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 714 UPSHUR ST.,N.W. WASHINGTON, D.C. 20011
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): HARMONY MEMORIAL PARK — DATE: 6/16
20c. LOCATION — City or Town, State: LANDOVER, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Alex S. Pope Jr. M859
22. NAME AND ADDRESS OF FACILITY: ALEXANDER S. POPE FUNERAL HOMES 5538 MARLBORO PIKE, FORESTVILLE,MD 20747

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	ASPIRATION	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	GASTROSTOMY FEEDER	
DUE TO (OR AS A CONSEQUENCE OF):		
c.	CEREBROVASCULAR ACCIDENT	
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Gary W. Jones Md
29c. LICENSE NUMBER: D 30111
29d. DATE SIGNED (Month, Day, Year): ▶ 06-12-95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): GARY W. JONES M.D. 11305 PITSEA DR.,BELTSVILLE, MARYLAND 20705

31. DATE FILED (Month, Day, Year): JUN 16 1995
32. REGISTRAR'S SIGNATURE: Julia Davidson Parker

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DHMH-18 Rev 1/89

95 20189

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Annie clyde Birch			2. DATE OF DEATH (Month, Day, Year): June 7 1995	3. TIME OF DEATH: 21:04 M
4. SOCIAL SECURITY NUMBER: 420-36-3035	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 73 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): August 13, 1921	8. BIRTHPLACE (State or Foreign Country): Alabama
9a. FACILITY NAME (If not institution, give street and number): Washington Adventist Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Takoma Park, Maryland		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: maryland	10b. COUNTY: Prince George	10c. CITY, TOWN OR LOCATION: fort Washington Maryland	10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 6611 Highsate Drive		10f. ZIP CODE: 20744	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CAshier	16b. KIND OF BUSINESS/INDUSTRY: Drug Store	
17. FATHER'S NAME (First, Middle, Last): Albert Tolliver		18. MOTHER'S NAME (First, Middle, Maiden Surname): Lucy Tolliver	
19a. INFORMANT'S NAME (Type/Print): Patricia Birch Morris	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6611 Highstate Dr. Ft. Wash. Md 20744		
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Eternal Rest DATE: 6/14/95	20c. LOCATION — City or Town, State: Montgomery Alabama	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Bruce Edwards	22. NAME AND ADDRESS OF FACILITY: 3910 Silver Hill Rd. Suitland, Md. Hodges & Edwards		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CARDIAC ARREST	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. MYOCARDIAL INFARCTION	
DUE TO (OR AS A CONSEQUENCE OF):		
	c. DIABETES	
DUE TO (OR AS A CONSEQUENCE OF):		
	d. CHRONIC RENAL FAILURE / HYPERTENSION	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☑ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: William J Levy MD	29c. LICENSE NUMBER: D0139627	29d. DATE SIGNED (Month, Day, Year) ▶ 6/8/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): William J. Levy MD 2955 CRAIN HIGHWAY WALDORF MD

31. DATE FILED (Month, Day, Year): JUN 14 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall 20601

DHMH-16 Rev 1/89

95 20190

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

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DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Gilbert L Buchanan SR.			2. DATE OF DEATH: Month June, Day 6, Year 95	3. TIME OF DEATH: 10:25 P M
4. SOCIAL SECURITY NUMBER: 578-64-4104	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 47 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): OCT 2, 1947
8. BIRTHPLACE (State or Foreign Country): WASH.,D.C.				

9a. FACILITY NAME (If not institution, give street and number): HOLY CROSS HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH: SILVER SPRING	9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE: NA	10b. COUNTY: NA	10c. CITY, TOWN OR LOCATION: WASHINGTON, D.C.	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 5013 SOUTH DAKOTA AVENUE, N.E.		10f. ZIP CODE: 20017	10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO; IF YES, GIVE WAR OR DATES: 1966-1971	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12):	College (1-4 or 5+): 5+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): FEDERAL PROTECTIVE OFF.	16b. KIND OF BUSINESS/INDUSTRY: U.S. GOVERNMENT

17. FATHER'S NAME (First, Middle, Last): VOYD BUCHANAN	18. MOTHER'S NAME (First, Middle, Maiden Surname): EDELL JOHNSON

19a. INFORMANT'S NAME (Type/Print): LORRAINE BUCHANAN (WIFE)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9873 WISKEY RUN, LAUREL, MARYLAND 20723

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): G.W. CEM ASP GARDENS	DATE: 6/13	20c. LOCATION — City or Town, State: ADELPHI, MARYLAND

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Alex S Pope Jr M895	22. NAME AND ADDRESS OF FACILITY: ALEXANDER S. POPE FUNERAL HOMES 5538 MARLBORO PIKE, FORESTVILLE, MD 20747

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic Heart Disease	30 min
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): b.	
	DUE TO (OR AS A CONSEQUENCE OF): c.	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John Dawson MD	29c. LICENSE NUMBER: D08546	29d. DATE SIGNED (Month, Day, Year): June 6 95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John Dawson MD 8218 Wisconsin Ave Bethesda		
31. DATE FILED (Month, Day, Year): JUN 09 1995	32. REGISTRAR'S SIGNATURE: John Dawson-Nadal	

(10)

DHMH-18 Rev 1/89

95 20191

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Johnny Ervin BELL A.K.A. John Ervin Bell			2. DATE OF DEATH (Month, Day, Year): June 7, 1995	3. TIME OF DEATH: 9:01P M
4. SOCIAL SECURITY NUMBER: 252-38-8695	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 62 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): June 12, 1932	8. BIRTHPLACE (State or Foreign Country): Georgia
9a. FACILITY NAME (If not institution, give street and number): Doctor's Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Lanham		9c. COUNTY OF DEATH: Prince George's

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Severn	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 241 Sheila K Court		10f. ZIP CODE: 21144	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Roofer	16b. KIND OF BUSINESS/INDUSTRY: Construction	
17. FATHER'S NAME (First, Middle, Last): Bertram B. Bell		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ruby Lee Kalahan	
19a. INFORMANT'S NAME (Type/Print): Sylvia Bell	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 241 Sheila K. Court, Severn, Maryland 21144		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan Crematory DATE: 6/12/95	20c. LOCATION — City or Town, State: Alexandria, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Charles F Bell IV	22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home- 4739 Baltimore Ave., Hyattsville, Md. 20781		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Ventricular arrythmia	2dd
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Atherosclerosis	2yr.
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Peripheral vascular disease; IDDM

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [X] NO [ ] UNCERTAIN [ ]	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD	29c. LICENSE NUMBER: D35820	29d. DATE SIGNED (Month, Day, Year) ▶ 6/9/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Peter Eckberg MD 14300 Gallant Fox Lane #110 Bowie, MD 20715		
31. DATE FILED (Month, Day, Year): JUN 13 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 20192

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EMMA BERRY			2. DATE OF DEATH (Month, Day, Year): JUNE 9, 1995	3. TIME OF DEATH: 1:15 AM
4. SOCIAL SECURITY NUMBER: 577-28-8467	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 96 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): SEPT. 3, 1898	8. BIRTHPLACE (State or Foreign Country): MD CHARLES COUNTY,
9a. FACILITY NAME (If not institution, give street and number): SOUTHERN MARYLAND HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: CLINTON	9c. COUNTY OF DEATH: PRINCE GEORGE'S

RESIDENCE OF DECEDENT

10a. STATE: N/A	10b. COUNTY: N/A	10c. CITY, TOWN OR LOCATION: WASHINGTON, DC	10d. INSIDE CITY LIMITS? ☒ 1 YES 2 ☐ NO
10e. STREET AND NUMBER: 3810 V STREET SE #101		10f. ZIP CODE: 20020	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DOMESTIC	16b. KIND OF BUSINESS/INDUSTRY: PVT.	
17. FATHER'S NAME (First, Middle, Last): EDMUND JACKSON		18. MOTHER'S NAME (First, Middle, Maiden Surname): UNKNOWN	
19a. INFORMANT'S NAME (Type/Print): IRENE B. THOMAS/ DAUGHTER	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3810 V STREET SE #101 WASHINGTON, DC 20020		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): HARMONY MEMORIAL CEM. DATE: 6-12-95	20c. LOCATION — City or Town, State: LANDOVER, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Shawana L. Brayton	22. NAME AND ADDRESS OF FACILITY: J.B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MD 20785		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Urinary Tract Infection DUE TO (OR AS A CONSEQUENCE OF):	3 days
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Bronchopneumonia Dementia

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: O'Haye	29c. LICENSE NUMBER: D26352	29d. DATE SIGNED (Month, Day, Year): ▶ June 9 95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): O L HAYE 9131 Piscataway Rd Clinton Md 20735		
31. DATE FILED (Month, Day, Year): JUN 15 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DNMN-16 Rev 1/89

95 20193

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Lercy T. BOOTH, Jr.					2. DATE OF DEATH (Month, Day, Year): June 18, 1995	3. TIME OF DEATH: 1:30 a M
4. SOCIAL SECURITY NUMBER: 213-38-2447	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 68 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): June 23, 1926	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Charlotte Hall Veterans Home			9b. CITY, TOWN OR LOCATION OF DEATH: Charlotte Hall		9c. COUNTY OF DEATH: St. Marys	
RESIDENCE OF DECEDENT						
10a. STATE: Maryland	10b. COUNTY: Calvert		10c. CITY, TOWN OR LOCATION: Owings		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO	
10e. STREET AND NUMBER: 161 Booth Haven Lane			10f. ZIP CODE: 20736		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: May 1946-Apr. 1947		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10 / College (1-4 or 5+):			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Farmer		16b. KIND OF BUSINESS/INDUSTRY: Tobacco	
17. FATHER'S NAME (First, Middle, Last): Lercy Booth, Sr.			18. MOTHER'S NAME (First, Middle, Maiden Surname): Rebecca Wills			
19a. INFORMANT'S NAME (Type/Print): Ethel Duppins			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 443 Owings, MD 20736			
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): MD Veterans Cemetery DATE: 6/22/95		20c. LOCATION — City or Town, State: Cheltenham, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Spencer E Sewell			22. NAME AND ADDRESS OF FACILITY: Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. DECUBITUS ULCER	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. PVD	YEARS
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. HYPERTENSION	YEARS
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CONGESTIVE HEART FAILURE

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined		M	1 [ ] YES 2 [ ] NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
	079657	▶ 6/19/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles Judge, M.D. Prince Frederick, MD 20678

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 21 1995	Julia Snowden-Randall

2+1

DHMH-16 Rev 1/89

95 20194

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Kathryn M. Boone
2. DATE OF DEATH (Month, Day, Year): June 19, 1995
3. TIME OF DEATH: 7:10 A M
4. SOCIAL SECURITY NUMBER: 216-14-6270
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 80 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year):
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Frederick
9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Carroll
10c. CITY, TOWN OR LOCATION: Westminster
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 2325 Manchester Road
10f. ZIP CODE: 21157
10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: n/a
17. FATHER'S NAME (First, Middle, Last): Clyde Young
18. MOTHER'S NAME (First, Middle, Maiden Surname): Irene Winbegler
19a. INFORMANT'S NAME (Type/Print): Sandra Irene Janocha
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2325 Manchester Rd., Westminster, MD 21157
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Hope Cemetery 6/21/95
20c. LOCATION — City or Town, State: Woodsboro, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Katherine Pitts-Switzer
22. NAME AND ADDRESS OF FACILITY: Pritts Funeral Home & Chapel, 412 Washington Rd., Westminster, MD

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Intracerebral Bleeding — DUE TO (OR AS A CONSEQUENCE OF):	< 24 hrs.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Hypertension — DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: None

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY:
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Swami Nath, M.D
29c. LICENSE NUMBER: D18414
29d. DATE SIGNED (Month, Day, Year): ▶ 6-15-95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SWAMI NATHAN, MD 207 W 7 St., FREDERICK, Md 21701
31. DATE FILED (Month, Day, Year): JUN 21 1995
32. REGISTRAR'S SIGNATURE: Julia [illegible]

DHMH-16 Rev 1/89

95 20195

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Joseph Andry Boone				2. DATE OF DEATH (Month, Day, Year): June 19 1995	3. TIME OF DEATH: 1:50 AM
4. SOCIAL SECURITY NUMBER: 213-24-8396	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 87 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): July 21, 1907	8. BIRTHPLACE (State or Foreign Country): Maryland
8a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Frederick		9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Johnsville	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 10943 Green Valley Rd.		10f. ZIP CODE: 21791	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Delivery	16b. KIND OF BUSINESS/INDUSTRY: Newspapers	
17. FATHER'S NAME (First, Middle, Last): Ernest Boone		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ida Pittinger	
19a. INFORMANT'S NAME (Type/Print): Thelma J. Boone		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10943 Green Valley Rd. Union Bridge, Md.21791	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): St. Peters Cemetery DATE: 6/23	20c. LOCATION — City or Town, State: Libertytown, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Delbert L Hartzler		22. NAME AND ADDRESS OF FACILITY: Hartzler Funeral Home Libertytown, Md. 21762	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. TG PHARYNGEAL CARCINOMA	6 MTH
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] ND

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)			
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Robert Kirk Jackson	D0039847	6/19/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ROBERT Kirk JACKSON MD 915 Tollhouse Ave Frederick, Md. 21701

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
6/19/95 JUN 21 1995	Julia Dawson Randall

DHMH-16 Rev 1/89

95 20196

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RICHARD CHARLES BIELKE			2. DATE OF DEATH (Month, Day, Year): June 10, 1995	3. TIME OF DEATH: 8:28 P M
4. SOCIAL SECURITY NUMBER: 387-18-9387	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 83 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 5, 1912	8. BIRTHPLACE (State or Foreign Country): Wisconsin
9a. FACILITY NAME (If not institution, give street and number): 1325 Saratoga Dr.		9b. CITY, TOWN OR LOCATION OF DEATH: Bel Air		9c. COUNTY OF DEATH: Harford
RESIDENCE OF DECEDENT				
10e. STATE: Maryland	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Bel Air		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1325 Saratoga Dr.		10f. ZIP CODE: 21014		10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Personnel Manager		16b. KIND OF BUSINESS/INDUSTRY: US Government
17. FATHER'S NAME (First, Middle, Last): Richard Rinehardt Bielke		18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Christine Schnuth		
19a. INFORMANT'S NAME (Type/Print): Junice E. Bielke		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1325 Saratoga Dr., Bel Air, Md. 21014		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Bel Air Memorial Gardens 6-16-95		20c. LOCATION — City or Town, State: Bel Air, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Howard K McComas III		22. NAME AND ADDRESS OF FACILITY: Howard K. McComas III Funeral Home, P.A. 50 W. Broadway St., Bel Air, Md. 21014		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute myocardial infarction	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Coronary artery disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Arteriosclerosis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [X]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible], MD	29c. LICENSE NUMBER: D08791	29d. DATE SIGNED (Month, Day, Year): June 14, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 846 S. MAIN ST. BEL AIR, MD. 21014		
31. DATE FILED (Month, Day, Year): JUN 15 1995	32. REGISTRAR'S SIGNATURE: [illegible]	

OHMH-16 Rev 1/89

20

95 20197

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RUBY T. BARNETT			2. DATE OF DEATH (Month, Day, Year): June 6, 1995	3. TIME OF DEATH: 12 Noon M
4. SOCIAL SECURITY NUMBER: 196-18-5177	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 93 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): Jan. 24, 1902	8. BIRTHPLACE (State or Foreign Country): Alabama
9a. FACILITY NAME (If not institution, give street and number): Madonna Heritage Home		9b. CITY, TOWN OR LOCATION OF DEATH: Jarrettsville		9c. COUNTY OF DEATH: Harford
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Jarrettsville		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3982 Norrisville Rd.		10f. ZIP CODE: 21084		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Weapons Tester	16b. KIND OF BUSINESS/INDUSTRY: Civil Service		
17. FATHER'S NAME (First, Middle, Last): Joseph Tooel		18. MOTHER'S NAME (First, Middle, Maiden Surname): Lula Barnes		
19a. INFORMANT'S NAME (Type/Print): Audrey Y. Cole	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 20722 Old York Road, Parkton, MD., 21120			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Nebo Cemetery	DATE: 6/10/95	20c. LOCATION — City or Town, State: Delta, PA.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John H. Tillett	22. NAME AND ADDRESS OF FACILITY: Harkins F.H. Inc., Delta, PA., 17314			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CHF (Congestive Heart failure) — Dap

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimers dx

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	28. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	26a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY M	26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	26d. DESCRIBE HOW INJURY OCCURED
	26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Mark Lamas	D34521	▶ 6/6/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mark Lamas, MD Papermill Road Jacksonville, MD

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 09 1995	Julia Davidson-Randall

DHMH-16 Rev 1/89

95 20198

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mary Annabelle Billingsley			2. DATE OF DEATH (Month, Day, Year): June 16, 1995	3. TIME OF DEATH: 9:20 A M
4. SOCIAL SECURITY NUMBER: 217-18-2019	5. SEX: 1 ☐ M 2 ☒ F	8. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Feb 15 1919	6. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Physicians Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: La Plata		9c. COUNTY OF DEATH: Charles
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Brandywine		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 8600 Dyson Road		10f. ZIP CODE: 20613		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY: Own Home		
17. FATHER'S NAME (First, Middle, Last): Charles Rawlings		18. MOTHER'S NAME (First, Middle, Maiden Surname): Pearl Colbert		
19a. INFORMANT'S NAME (Type/Print): Mary A. Breece	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8600 Dyson Road Brandywine, MD 20613			
20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Cem of Cedarville Assembly of God	DATE: 6-19-95	20c. LOCATION — City or Town, State: Cedarville, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John H. Eberwein	M00173	22. NAME AND ADDRESS OF FACILITY: J.H. Eberwein Mortuary 4433 White Pls La White Pls., MD 20695		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Seizures	5 days
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. atrial fib with Rapid Ventricular Response	1 day
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Progressive Neurologic disorder
Possible CVA Possible Meningioma

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO; 28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one):
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Oswald Haye	29c. LICENSE NUMBER: D26352	29d. DATE SIGNED (Month, Day, Year): 6 June 95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): OL Haye MD 9131 Piscataway Rd Clinton MD 20735		
31. DATE FILED (Month, Day, Year): JUN 19 1995	32. REGISTRAR'S SIGNATURE: Julia Thurlow Randall	

OHMH-16 Rev 1/89

95 20199

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
MERRITT	C.	Batchelder	June 13 1995	1935 M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
579-44-7183	1 X M 2 ☐ F	93 YRS.			Sept. 19 1901	NEW YORK

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MARYLAND	SOMERSET	PRINCESS ANNE	1 ☐ YES 2 X NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
26658 MT. VERNON ROAD	21853	U.S.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☑ NO	1 ☐ YES 2 ☑ NO Specify:	Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12	5+	PROFESSER	COLLEGE

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
MERRITT BATCHELDER	MILDRED BILLINGS

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
PAULINE MANNING BATCHELDER	26658 MT. VERNON ROAD, PRINCESS ANNE, MD. 21853

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place)	DATE	20c. LOCATION — City or Town, State
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	ASBURY CEMETERY	6/17	MT. VERNON, MD.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ James L Hinman Jr. M00295	HINMAN FUNERAL HOME PRINCESS ANNE, MD. 21853

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Non-lymphocytic leukemia	2 months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Sepsis
Renal Failure

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 X NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)
1 ☐ YES 2 X NO	HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
J. E. Martin, M.D.	030690	▶ 6/14/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
James E. Martin, M.D., 145 E. Carroll St., Salisbury, MD.

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 15 1995	Jodie Henderson Randall

DHMH-16 Rev 1/89

95 20200

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Estella Frances BURK			2. DATE OF DEATH (Month, Day, Year): June 18, 1995	3. TIME OF DEATH: 11:25 A. M
4. SOCIAL SECURITY NUMBER: 168-14-0643	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Aug. 1, 1920	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): Citizens Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick		9c. COUNTY OF DEATH: Frederick
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Frederick		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2200 Rosemont Avenue		10f. ZIP CODE: 21702		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own home		
17. FATHER'S NAME (First, Middle, Last): Harry E. Bowers		18. MOTHER'S NAME (First, Middle, Maiden Surname): Della M. Keller		
19a. INFORMANT'S NAME (Type/Print): Patricia Stockman	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 910 Seminole Road, Frederick, Md. 21701			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) _____	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Arlington National Cemetery	DATE: June 21, 1995	20c. LOCATION — City or Town, State: Ft. Myer, Va.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Richard C. C. Basford M00021	22. NAME AND ADDRESS OF FACILITY: Keeney and Basford Funeral Home 106 East Church St., Frederick, Md. 21701			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. PULMONARY EDEMA	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. CONGESTIVE HEART FAILURE	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DENTIA

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☑

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D43091	29d. DATE SIGNED (Month, Day, Year): ▶ June 19, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Saeed A. Zaidi, M.D. 801 Toll House Ave., Frederick, Md. 21701		
31. DATE FILED (Month, Day, Year): JUN 21 1995	32. REGISTRAR'S SIGNATURE: John Davidson-Randall	

DHMH-16 Rev 1/89

95 20201

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Eugene Blessing Boyer SR.			2. DATE OF DEATH (Month, Day, Year): June 17, 1995	3. TIME OF DEATH: 7:45 P M
4. SOCIAL SECURITY NUMBER: 217-28-1427	5. SEX: 1 XX M 2 ☐ F	6. AGE (In yrs. last birthday): 66 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Nov. 20, 1928	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Washington Adventist Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Takoma Park		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Knoxville	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 XX NO
10e. STREET AND NUMBER: 2242 Jefferson Pike		10f. ZIP CODE: 21758	10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Owned and Operated	16b. KIND OF BUSINESS/INDUSTRY: Milk Transportation Co.	
17. FATHER'S NAME (First, Middle, Last): William Blessing BOYER		18. MOTHER'S NAME (First, Middle, Maiden Surname): Nannie Gertrude BOYER	
19a. INFORMANT'S NAME (Type/Print): Mrs. Joan F. Boyer		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2242 Jefferson Pike, Knoxville, Md. 21758	
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): St. Marys Cemetery	DATE: June 22, 1995	20c. LOCATION — City or Town, State: Petersville, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Richard E. Hood	M00255	22. NAME AND ADDRESS OF FACILITY: Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Pulmonary embolism	Two hours
DUE TO (OR AS A CONSEQUENCE OF):	Myocardial Infarction	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.		
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 X YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 XX Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

26a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY M	26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	26d. DESCRIBE HOW INJURY OCCURED
26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D 28883	29d. DATE SIGNED (Month, Day, Year): ▶ June 18, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Anjum Qazi, M.D. 1706 New Hampshire Avenue, N.W., Washington, D.C. 20009

31. DATE FILED (Month, Day, Year): JUN 21 1995	32. REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89

95 20202

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Frances Jean BOYER

2. DATE OF DEATH (Month, Day, Year): June 17, 1995

3. TIME OF DEATH: 8:40 A. M

4. SOCIAL SECURITY NUMBER: 218-24-1419

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 66 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): Sept. 18, 1928

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): Meridian Nursing Home

9b. CITY, TOWN OR LOCATION OF DEATH: Frederick

9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Frederick

10c. CITY, TOWN OR LOCATION: Frederick

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 501 Prospect Blvd., Apt. 32-B

10f. ZIP CODE: 21701

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)

Elementary/Secondary (0-12): 11

College (1-4 or 5 +):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Administrative Assistant

16b. KIND OF BUSINESS/INDUSTRY: U.S. Government

17. FATHER'S NAME (First, Middle, Last): Charles Henry Boyer

18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Margaret Virginia Cochron

19a. INFORMANT'S NAME (Type/Print): Charles Boyer

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 501 Prospect Blvd., Apt. 7-A. Frederick, Md. 21701

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Reformed Cemetery — DATE: June 20, 1995

20c. LOCATION — City or Town, State: Middletown, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Allan H Ruby M00703

22. NAME AND ADDRESS OF FACILITY: Keeney and Basford Funeral Home ~~106 East Church Street, Frederick, Md. 21701~~

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. adenocarcinoma of lung — DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. (mets-smaller) — DUE TO (OR AS A CONSEQUENCE OF):

c. — DUE TO (OR AS A CONSEQUENCE OF):

d.

Approximate Interval Between Onset and Death: 6 mo

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)

HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)

1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: H Robert S Hughes

29c. LICENSE NUMBER: D0511

29d. DATE SIGNED (Month, Day, Year): 6/19/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Robert S. Hughes, M.D., 700 Montclaire Avenue, Frederick, MD 21701

31. DATE FILED (Month, Day, Year): JUN 19 1995

32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DHMH-16 Rev 1/89

95 20203

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EVA MILLER BADALAMENTI			2. DATE OF DEATH (Month, Day, Year): June 14, 1995	3. TIME OF DEATH: 4:00 pM
4. SOCIAL SECURITY NUMBER: 051-03-5176	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 88 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): June 10, 1907	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Meridian Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick	9c. COUNTY OF DEATH: Frederick	
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Walkersville	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO	
10e. STREET AND NUMBER: 2823 Wildwood Court		10f. ZIP CODE: 21793	10g. CITIZEN OF WHAT COUNTRY?: United States	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): UNKNOWN; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Self		
17. FATHER'S NAME (First, Middle, Last): UNKNOWN	18. MOTHER'S NAME (First, Middle, Maiden Surname): Bessie Lee Boswell			
19a. INFORMANT'S NAME (Type/Print): Evelyn Zimmerman	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2823 Wildwood Court Walkersville, MD 21793			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Evergreen Mem Gardens DATE: 6/16/95	20c. LOCATION — City or Town, State: Lexington,Park, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Kenny R. Stauffer	22. NAME AND ADDRESS OF FACILITY: Stauffer Funeral Homes, P.A. 40 Fulton Ave. Walkersville, MD 21793			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ASCVD.	10 yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Andrew Zarick MD	29c. LICENSE NUMBER: D35164	29d. DATE SIGNED (Month, Day, Year): 6/15/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Andrew Zarick P.O. Box 369 Walkersville, Maryland 21793

31. DATE FILED (Month, Day, Year): JUN 16 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

95 20204

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
REGINALD		BRYANT	June 6, 1995	10:40 AM

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
217-10-0741	1 [X] M 2 [ ] F	77 YRS.			June 25, 1917	Pennsylvania

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Northampton Manor Nursing Home	Frederick	Frederick

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Frederick	Frederick	1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
205 West South Street	21701	United States

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES?	13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII	1 [ ] YES 2 [X] NO Specify:	Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
11		Carrier	U.S. Postal Service

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Arthur Bryant	Venetta Makel

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Anna Lawson Bryant	205 W. South Street Frederick, Maryland 21701

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Resthaven Memorial Gardens	6/9/95	Frederick, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
[signature]	Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, MD 21702

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Prostate Cancer	> 1 yr.
	OUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. OUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

Insulin Dependent Diabetes mellitus

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [ ] YES 2 [X] NO	HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined		M	1 [ ] YES 2 [ ] NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	D-18191	▶ 6-7-95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Manalo, Arthur, M.D. 187 Thomas Johnson Dr., Frederick, MD 21702

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 19 1995	[signature]

DHMH-16 Rev 1/89

95 20205

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
Ralph	Vincent	Buckbee	June 3, 1995	5:00 A M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
057-24-2644	1 [X] M 2 [ ] F	62 YRS.			Dec. 3, 1932	Albany New York

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
309 Sunset Lane	Prince Frederick	Calvert

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Calvert	Prince Frederick	1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
309 Sunset Lane	20678	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] YES 2 [ ] NO 1950-1953	1 [ ] YES 2 [X] NO Specify:	Specify: Caucasian

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12th	2	Aircraft Mechanic	Andrews Air Force Base

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Ralph Buckbee	Ester Saulkel

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Joan Buckbee	309 Sunset Lane Prince Frederick Maryland 20678

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Arlington National Cem.	June 8, 1995	Arlington Virginia

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶	Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, Md 20735

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Sudden Cardiac death.
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Severe L.V. dysfunction and CHF
DUE TO (OR AS A CONSEQUENCE OF):
c. CAD.
DUE TO (OR AS A CONSEQUENCE OF):
d. Cardiac arrhythmias

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [X] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)
1 [ ] YES 2 [X] NO	HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] YES 2 [ ] NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Kiumarse Yazdani	D17168	▶ 6/6/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr, Yazdani 2555 Solomons Island Road Huntingtown, Md 20639

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 20 1995	Julia Theodosia Randall

DHMH-16 Rev 1/89

95 20206

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ELWOOD CLARENCE BENNETT
2. DATE OF DEATH (Month, Day, Year): JUNE 17, 1995
3. TIME OF DEATH: 6:06 A M
4. SOCIAL SECURITY NUMBER: 216-70-1770
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 38 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)
7. DATE OF BIRTH (Month, Day, Year): AUGUST 9, 1956
8. BIRTHPLACE (State or Foreign Country): DELAWARE
9a. FACILITY NAME (If not institution, give street and number): 222 METEOR AVENUE, APT. 101
9b. CITY, TOWN OR LOCATION OF DEATH: CAMBRIDGE
9c. COUNTY OF DEATH: DORCHESTER

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: DORCHESTER
10c. CITY, TOWN OR LOCATION: CAMBRIDGE
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 222 METEOR AVENUE, APT. 101
10f. ZIP CODE: 21613
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4 or 5+): 2
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CHEF
16b. KIND OF BUSINESS/INDUSTRY: RESTAURANT
17. FATHER'S NAME (First, Middle, Last): ROBERT GALE BENNETT
18. MOTHER'S NAME (First, Middle, Maiden Surname): KATHLEEN HENRY
19a. INFORMANT'S NAME (Type/Print): KATHLEEN BENNETT
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 222 METEOR AVENUE, APT. 101, CAMBRIDGE, MD 21613
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): GALESTOWN CEMETERY — DATE: 6/19
20c. LOCATION — City or Town, State: GALESTOWN, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Leonard D Zeller
22. NAME AND ADDRESS OF FACILITY: ZELLER FUNERAL HOME, P. O. BOX 207, 106 MAIN STREET, EAST NEW MARKET, MD 21631

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Aids -	7 yrs
DUE TO (OR AS A CONSEQUENCE OF): b.	Resistant Oral Esophageal Candd	< 3 mos
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	Kaposi's Sarcoma	< 2 yrs
d.	Lymphoma	4 yrs

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Judy C. Washington MD
29c. LICENSE NUMBER: D31108
29d. DATE SIGNED (Month, Day, Year): ▶ 6/20/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Judy C. Washington 302 Callins Ave, Hurlock MD 21643
31. DATE FILED (Month, Day, Year): JUN 21 1995
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

2

95 20207

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ALVIN ROBERTSON BROWN, III			2. DATE OF DEATH (Month, Day, Year): JUNE 25 1995	3. TIME OF DEATH: 2 A M
4. SOCIAL SECURITY NUMBER: 220-40-1747	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 52 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): October 3, 1942	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Stella Maris Hospice		9b. CITY, TOWN OR LOCATION OF DEATH: Towson		9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Pennsylvania	10b. COUNTY: York	10c. CITY, TOWN OR LOCATION: New Freedom	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 108 Freedom Ave.		10f. ZIP CODE: 17349	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Service Repairman	16b. KIND OF BUSINESS/INDUSTRY: Vending Company	
17. FATNER'S NAME (First, Middle, Last): Alvin R. Brown, Sr.		18. MOTNER'S NAME (First, Middle, Maiden Surname): Ida Marie Truitt	
19a. INFORMANT'S NAME (Type/Print): Alvin R. Brown, IV	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): R.R.#1, Box 710, Brodbecks, Pa. 17329		
20a. METNOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other piece): New Freedom Cemetery — DATE: 6/28/95	20c. LOCATION — City or Town, State: New Freedom, Pa.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Karen D. Dunkle	22. NAME AND ADDRESS OF FACILITY: J.J.Hartenstein Mortuary, 24 Second St., New Freedom, Pa. 17349		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CANCER OF THE LARYNX	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [X] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) HOSPICE		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Kendall R. Faulkner MD	29c. LICENSE NUMBER: D 25643	29d. DATE SIGNED (Month, Day, Year): 6/26/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204

31. DATE FILED (Month, Day, Year): JUN 29 1995	32. REGISTRAR'S SIGNATURE: Julia Dudas-Randall

DHMH-16 Rev 1/89

95 20208

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Dorothy Virginia Barnes
2. DATE OF DEATH (Month, Day, Year): June 10, 1995
3. TIME OF DEATH: 3:11 A M
4. SOCIAL SECURITY NUMBER: 220-03-2839
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 74 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Mar 5, 1921
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Harford Memorial Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Havre de Grace
9c. COUNTY OF DEATH: Harford

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Cecil
10c. CITY, TOWN OR LOCATION: Rising Sun
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 27 Louise Ct.
10f. ZIP CODE: 21911
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Minister
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Allen Bond
18. MOTHER'S NAME (First, Middle, Maiden Surname): Edna
19a. INFORMANT'S NAME (Type/Print): James Theodore Jackson
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 27 Louise Ct Rising Sunm MD
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): St James Cem — DATE: 6-17
20c. LOCATION — City or Town, State: Havre de Grace, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: Beard Funeral Home 552 Lewis St Havre de Grace, MD 21078

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Congestive heart failure	10 hours
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Coronary artery disease	
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. LICENSE NUMBER: D31712
29d. DATE SIGNED (Month, Day, Year): ▶ 6/10/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CHARLES ECK JR 219 W. BELAIR AVE. ABERDEEN, MD 21001

31. DATE FILED (Month, Day, Year): JUN 15 1995
32. REGISTRAR'S SIGNATURE: [signature] Rendall

DHMH-16 Rev 1/89

95 20209

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RUBY CAMPBELL		2. DATE OF DEATH (Month, Day, Year): 6 / 4 / 1995	3. TIME OF DEATH: 9:30 a M
4. SOCIAL SECURITY NUMBER: 578-26-6484	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 70 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 1/31/1925
8. BIRTHPLACE (State or Foreign Country): King william, VA			
9a. FACILITY NAME (If not institution, give street and number): HOLY CROSS HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH: SILVER SPRING	9c. COUNTY OF DEATH: MONTGOMERY	
RESIDENCE OF DECEDENT			
10a. STATE: DC	10b. COUNTY: N/A	10c. CITY, TOWN OR LOCATION: WASHINGTON, DC	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1516 Oates Street, N.E.	10f. ZIP CODE: 20002	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: NEGRO
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): 2 years	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Book Binder	16b. KIND OF BUSINESS/INDUSTRY: Printing	
17. FATHER'S NAME (First, Middle, Last): CHARLESTON TEMPLE	18. MOTHER'S NAME (First, Middle, Maiden Surname): FLORA HILL		
19a. INFORMANT'S NAME (Type/Print): FLORA TEMPLE	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 611 Edgewood St., NE #816 - Wash. DC 20017		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place): Oak Grove Baptist Church; DATE: 6/10/95	20c. LOCATION — City or Town, State: Manquin, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Philip J. Kay	22. NAME AND ADDRESS OF FACILITY: John T. Rhines & Co. 3030 - 12th Street, NE Washington, DC 20017		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Bilateral Pneumonia	1 day
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure; Dementia

Chronic Renal Failure

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Martin C. Shargel M.D.	D 08944	▶ 6/4/1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Martin C. Shargel, M.D. 3720 Farragut Ave. - Kenington, MD 20895

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 16 1995	Julia Davidson-Randall

DHMH-16 Rev 1/89

95 20210

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Carolyn S. Padgett- Churchin			2. DATE OF DEATH (Month, Day, Year): June 4, 1995	3. TIME OF DEATH: 3:25 PM
4. SOCIAL SECURITY NUMBER: 228-72-3075	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 45 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): July 24, 1949	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 2067 Happy Lane (Residence)		9b. CITY, TOWN OR LOCATION OF DEATH: Crofton		9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Crofton	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 2067 Happy Lane		10f. ZIP CODE: 21114	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Telephone Operator	16b. KIND OF BUSINESS/INDUSTRY: Bell Atlantic	
17. FATHER'S NAME (First, Middle, Last): James Edward Sanders		18. MOTHER'S NAME (First, Middle, Maiden Surname): Marian Dutrow	
19a. INFORMANT'S NAME (Type/Print): Paul F. Churchin	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2067 Happy Lane , Crofton, Md 21114		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery DATE: June 9, 1995	20c. LOCATION — City or Town, State: Suitland, Md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home, Inc 6633 Old Alexander Ferry ROad, Clinton, Md 20735		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Asphyxia	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Hanging	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO X

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 06/04/95	28b. TIME OF INJURY: UNK M	28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO
	28d. DESCRIBE HOW INJURY OCCURED: Hung Self		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): HOME	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Crofton, Md.	

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] and Deputy	29c. LICENSE NUMBER: D06054	29d. DATE SIGNED (Month, Day, Year): 06/04/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): William P. Jones, MD 695 America Court, Davidson , Maryland 21035

31. DATE FILED (Month, Day, Year): JUN 16 1995	32. REGISTRAR'S SIGNATURE: [signature]

(20)

DHMH-18 Rev 1/89

95 20211

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Leonard Clark		2. DATE OF DEATH: Month June, Day 10, Year 1995	3. TIME OF DEATH: 11:50 PM
4. SOCIAL SECURITY NUMBER: 214 32 8516	5. SEX: 1 XX M 2 ☐ F	6. AGE (In yrs. last birthday): 59 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): May 24 1935
8. BIRTHPLACE (State or Foreign Country): Maryland			
9a. FACILITY NAME (If not institution, give street and number): Greater Laurel-Beltsville Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Laurel	9c. COUNTY OF DEATH: Prince George's	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Bowie	10d. INSIDE CITY LIMITS? XX 1 YES 2 ☐ NO
10a. STREET AND NUMBER: 13331 East 11th Street	10f. ZIP CODE: 20715	10g. CITIZEN OF WHAT COUNTRY?: United States	

11. MARITAL STATUS: 1 ☐ Never Married XX Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO. IF YES, GIVE WAR OR DATES: No	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify: No	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Machinist	16b. KIND OF BUSINESS/INDUSTRY: Plastic Plant	
17. FATHER'S NAME (First, Middle, Last): Leonard C. Clark, Sr.	18. MOTHER'S NAME (First, Middle, Maiden Surname): Gertrude M. Martin Reeves		
19a. INFORMANT'S NAME (Type/Print): Shirley M. Clark	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13331 East 11th Street Bowie Md. 20715		
20a. METHOD OF DISPOSITION: XX 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place): Maryland National Memorial Park		20c. LOCATION — City or Town, State: 6/14/95 Laurel Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert E. Evans Pres.	22. NAME AND ADDRESS OF FACILITY: Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Sepsis	3 months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Renal Failure	1 yr
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Diabetes Mellitas	20yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anoxic encephalopathy
Peripheral Vascular Disease

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☑

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO; 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: N. Placenta M.D. Physician	29c. LICENSE NUMBER: H35116	29d. DATE SIGNED (Month, Day, Year): 6/11/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): N. Placenta D.O. 11018 Lockwood Dr. Silver Spring, MD 20901		
31. DATE FILED (Month, Day, Year): 6/11/95 JUN 14 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson Reeves	

DHMH-16 Rev 1/89

95 20212

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DELLA KATE CHEWNING			2. DATE OF DEATH (Month, Day, Year): JUNE 10, 1995	3. TIME OF DEATH: 5:05 PM
4. SOCIAL SECURITY NUMBER: 579-42-3221	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 65 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): March 31, 1930	8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): SOUTHERN MARYLAND HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: CLINTON	9c. COUNTY OF DEATH: PRINCE GEORGES	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Capitol Heights	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 4119 Shell Street	10f. ZIP CODE: 20743	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Custodian	16b. KIND OF BUSINESS/INDUSTRY: Government	
17. FATHER'S NAME (First, Middle, Last): Roy Edwards		18. MOTHER'S NAME (First, Middle, Maiden Surname): Pearl Spencer	
19a. INFORMANT'S NAME (Type/Print): Deborah Chewning/daughter	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4469 23rd Pkwy, #203, Temple Hills, MD 20748		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Harmony Memorial Park DATE: 6/16/1995	20c. LOCATION — City or Town, State: Landover, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Shawana L. Blanton	22. NAME AND ADDRESS OF FACILITY: J.B. JENKINS FUNERAL HOME 7474 Landover Rd., Landover, MD 20785		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Congest— heart failure	Unknown
DUE TO (OR AS A CONSEQUENCE OF):	b. END STAGE RENAL	Many years
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c. DUE TO (OR AS A CONSEQUENCE OF): Massive Abdominal wall hematoma	Recent
	d. DUE TO (OR AS A CONSEQUENCE OF): Respiratory insufficiency	Recent

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: K. Davachi Attending	29c. LICENSE NUMBER: D25640	29d. DATE SIGNED (Month, Day, Year): 6/12/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): KHOSROW DAVACHI 1328 SOUTHERN AVENUE WASHINGTON DC 20032

31. DATE FILED (Month, Day, Year): JUN 15 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

95 20213

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)	2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
Joseph John Choroszej	June 17, 1995	1 PM

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
366-14-9861	1 [X] M 2 [ ] F	77 YRS.			Sept. 8, 1917	MASS

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Citizens Nursing Home	Havre de Grace	Harford

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Harford	Havre de Grace	1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
1208 Revolution Street	21078	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES?	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII	1 [ ] YES 2 [X] NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
GED		Material Training	Federal Government

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Walter Choroszej	Adela Komziszcza

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Jean F. Choroszej	1208 Revolution Street, Havre de Grace, MD 21078

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Mt. Erin Cemetery	6/21	Havre de Grace, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ William S Smith II	Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. END STAGE OF MYELOFIBROSIS.	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. CONGESTIVE HEART FAILURE	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. LIVER FAILURE (Hepatic insufficiency)	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. ARRHYTHMIA	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PNEUMONIA ANEMIA DEPRESS.
CHRONIC OBSTRUCTIVE PULMONARY DISEASE

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [ ] YES 2 [X] NO	HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined		M	1 [ ] YES 2 [ ] NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29e. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
H. SHIP SIM MD.	D46412	▶ 6/18/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
H. SHIP SIM MD. 195 S. UNION AVE HAVRE DE GRACE MD 21078

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 20 1995	Gloria Davidson Randall

DHMH-16 Rev 1/89

95 20214

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

10+1

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
KENNETH	ANTHONY	CASSAT	June 16, 1995	10:20 A M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
217-26-5790	1 X M 2 ☐ F	74 YRS.			March 22, 1921	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
2812 Van Horn Road	Forest Hill	Harford

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Harford	Forest Hill	1 ☐ YES 2 X NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
2812 Van Horn Road	21050	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 X YES 2 ☐ NO — WWII	1 ☐ YES 2 X NO Specify:	Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12		Salesman	Auto Transmission Sales

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Benjamin Joseph Cassat	Mary Catherine Smith

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Theresa A. Cassat	2812 Van Horn Road, Forest Hill, Maryland 21050

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Highview Memorial Gardens	6-19-95	Fallston, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Howard K. McComas III	Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. metastatic carcinoma	2 wks
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. malignant melanoma	years
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ ND — NA

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☑ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
	D28136	▶ 6/16/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 20 1995	Lisa Thurston-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-3702-047
CIP

ITEMS: 23 PART I, 27, PER MEO FILM G-726 8/1/95 t.t

95 20215

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
DAVID	A.	CARROLL	JUNE 24, 1995	4:05 AM

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
208 58 5403	1 X M 2 ☐ F	31 YRS.			SEPT. 21, 1963	YORK, PA

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
ATLANTIC GENERAL HOSPITAL	OCEAN CITY	WORCHESTER

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
PA	YORK	YORK	1 X YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
340 B W. PRINCESS ST.	17404	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ YES 2 X NO	1 ☐ YES 2 X NO Specify:	Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12TH	—	DISABLED	—

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
PHILLIP CARROLL	GENICE CARLISLE

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
PHILLIP CARROLL	140 SYLVAN DR. YORK PA 17402

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	SUSQUEHANNA MEM. GDS.	6/28	YORK, PA

21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ Robert W. Ramsey

22. NAME AND ADDRESS OF FACILITY: JOHN W. KEFFER FUNERAL HOME, INC. 902 MT. ROSE AVE. YORK, PA 17403

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. SCHIZOPHRENIA	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 X YES 2 ☐ NO	1 X YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 X YES 2 ☐ NO	HOSPITAL: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
	O.C.M.E.	▶ JUNE 25, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
David R Fowler 111 Penn Street, Baltimore, Maryland 21201

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUL 06 1995	

DHMH-16 Rev 1/89

95-3503-025
blh

95 20216

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Richard James Colfer			2. DATE OF DEATH (Month, Day, Year): June 14, 1995	3. TIME OF DEATH: 0955 AM
4. SOCIAL SECURITY NUMBER: 577-12-0011	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Aug. 12, 1916	8. BIRTHPLACE (State or Foreign Country): Washington, DC

9a. FACILITY NAME (If not institution, give street and number): Calvary Road @ Schucks Road	9b. CITY, TOWN OR LOCATION OF DEATH: Bel Air	9c. COUNTY OF DEATH: Harford

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Darlington	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 2013 Trappe Church Rd.		10f. ZIP CODE: 21034	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 5	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Physician - Pathologist	16b. KIND OF BUSINESS/INDUSTRY: State Government

17. FATHER'S NAME (First, Middle, Last): John Thomas Colfer	18. MOTHER'S NAME (First, Middle, Maiden Surname): Caroline Mary Mohr
19a. INFORMANT'S NAME (Type/Print): Barbara A. L. Colfer	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2013 Trappe Church Rd., Darlington, Md. 21034

20a. METHOD OF DISPOSITION: [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Darlington Cemetery DATE: 6-17-95	20c. LOCATION — City or Town, State: Darlington, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Stephen A. Hughey	22. NAME AND ADDRESS OF FACILITY: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Md. 21009	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple injuries

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) at scene	
27. MANNER OF DEATH: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): June 14 1995	28b. TIME OF INJURY: 0956M	26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED: Driver in auto/ truck Impact		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): on street	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Calvary Rd @ Schucks Rd.	

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Donald G. Wright MD	29c. LICENSE NUMBER: O.C..M.E.	29d. DATE SIGNED (Month, Day, Year): June 14 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Donald G. Wright M.D. 111 Penn Street, Baltimore, Maryland 21201

31. DATE FILED (Month, Day, Year): JUN 16 1995	32. REGISTRAR'S SIGNATURE: John Theodore Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 20217

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Joseph Partick Creel			2. DATE OF DEATH (Month, Day, Year): June 14 1995	3. TIME OF DEATH: 12:45 P M
4. SOCIAL SECURITY NUMBER: 216-74-1376	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 38 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): August 7 1956	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): SOUTHERN MARYLAND HOSPITAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: CLINTON		9c. COUNTY OF DEATH: PRINCE GEORGE'S

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Charles	10c. CITY, TOWN OR LOCATION: Waldorf	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 10602 Arron Court		10f. ZIP CODE: 20603	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Letter Carrier	16b. KIND OF BUSINESS/INDUSTRY: US Postal Service	
17. FATHER'S NAME (First, Middle, Last): Manuel J. Creel		18. MOTHER'S NAME (First, Middle, Maiden Surname): Dorothy Linzer	
19a. INFORMANT'S NAME (Type/Print): Anne C. Creel	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10602 Arron Court Waldorf, MD 20603		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): St Josephs Church Cem. DATE: 6-17-95	20c. LOCATION — City or Town, State: Pomfret, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John A. Eberwein M00173	22. NAME AND ADDRESS OF FACILITY: J.H. Eberwein Mortuary 4433 White Pls La White Pls, MD 20695		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Colon Cancer — DUE TO (OR AS A CONSEQUENCE OF):	1-2 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Liver Metastasis — DUE TO (OR AS A CONSEQUENCE OF):	
	c. — DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
	D22574	6/14/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Robert Timothy Pace, M.D. P.O. Box 249 Waldorf MD 20604249

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 19 1995	Julia Davidson-Randall

DHMH-16 Rev 1/89

95 20218

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EVELYN MAE COLVIN			2. DATE OF DEATH (Month, Day, Year): June 22 95	3. TIME OF DEATH: 1 40 A M
4. SOCIAL SECURITY NUMBER: 171-24-8175	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 63 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): September 17, 1931	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): Stella Maris Hospice		9b. CITY, TOWN OR LOCATION OF DEATH: Towson		9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Pylesville	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 5222 West Heaps Road		10f. ZIP CODE: 21132	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher	16b. KIND OF BUSINESS/INDUSTRY: Education	
17. FATHER'S NAME (First, Middle, Last): Carl C. Moore, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Genevine Prentice	
19a. INFORMANT'S NAME (Type/Print): William L. Colvin, Jr.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): R.D#4, Box 4464, Glen Rock, Pa. 17327	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Stewartstown Cemetery	DATE: 6/24/95	20c. LOCATION — City or Town, State: Stewartstown, Pa.17363
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: J.J.Hartenstein Mortuary 19 S. Main St., Stewartstown, Pa. 17363	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. OVARIAN CANCER	2 mos,
	OUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. OUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF OEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence ☒ Other (Specify) Hospice	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Kendall R Faulkner MD	29c. LICENSE NUMBER: D25643	29d. DATE SIGNED (Month, Day, Year): ▶ 6/22/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204

31. DATE FILED (Month, Day, Year): JUN 2 9 1995	32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

95 20219

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JANNIE L. DIXON			2. DATE OF DEATH (Month, Day, Year): JUNE-8TH-95	3. TIME OF DEATH: 4-30 PM
4. SOCIAL SECURITY NUMBER: 215-26-2628	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 75 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): FEB-25-1920
8. BIRTHPLACE (State or Foreign Country): South Carolina				
9a. FACILITY NAME (If not institution, give street and number): LARKIN CHASE NURSING CENTER	9b. CITY, TOWN OR LOCATION OF DEATH: Bowie	9c. COUNTY OF DEATH: Prince George's		

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Landover	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 2412 Virginia Avenue, #101	10f. ZIP CODE: 20785	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Domestic Worker	16b. KIND OF BUSINESS/INDUSTRY: Private	

17. FATHER'S NAME (First, Middle, Last): Charley Patrick	18. MOTHER'S NAME (First, Middle, Maiden Surname): Jincie Izzard
19a. INFORMANT'S NAME (Type/Print): Margaret J. Mitchell	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11735 South Laurel Dr., #124, Laurel, MD 20708

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland National Cem.	DATE: Jun 16	20c. LOCATION — City or Town, State: Laurel, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Shawana L. Braxton	22. NAME AND ADDRESS OF FACILITY: J.B. JENKINS FUNERAL HOME 7474 Landover Rd., Landover, MD 20785		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. NOT KNOWN — ? RESPIRATORY FAILURE	< ONE HOUR
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. END STAGE RENAL FAILURE	> 8-Months
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. DIABETES MELLITUS	> YEARS
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. CORONARY ARTERY DISEASE	> YEARS

PART II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I.
Gangrene Right hand fingers; peripheral vascular disease; HTN; CHF; Bilateral-lower-limb-amputation

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO N/A.	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: S Rao MD	29c. LICENSE NUMBER: D-34525	29d. DATE SIGNED (Month, Day, Year): ▶ 06-09-95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): S.J. RAO, MD - 4000-Mitchellville Road; #220; BOWIE; MD-20716		
31. DATE FILED (Month, Day, Year): JUN 13 1995	32. REGISTRAR'S SIGNATURE: Julie Davidson Randall	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 20220

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOSEPH FRANKLIN DAVIS			2. DATE OF DEATH (Month, Day, Year): JUNE 9 1995	3. TIME OF DEATH: 9:00 pM
4. SOCIAL SECURITY NUMBER: 579-16-0261	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Sept. 23, 1920	8. BIRTHPLACE (State or Foreign Country): North Carolina
9a. FACILITY NAME (If not institution, give street and number): 5999 Emerson Street, Apt. #616		9b. CITY, TOWN OR LOCATION OF DEATH: Bladensburg		9c. COUNTY OF DEATH: PRINCE GEORGE'S

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Bladensburg	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 5999 Emerson Street, Apt. #616		10f. ZIP CODE: 20710	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: 1942 to 1946	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Warehouseman	16b. KIND OF BUSINESS/INDUSTRY: Moving and Storage	
17. FATHER'S NAME (First, Middle, Last): Charles Davis		18. MOTHER'S NAME (First, Middle, Maiden Surname): Nannie Jetton	
19a. INFORMANT'S NAME (Type/Print): Aurelia Davis Worthy	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6306 Radds Street, Lexington, NC 27292		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Fort Lincoln Cemetery DATE: 6/17/95	20c. LOCATION — City or Town, State: Brentwood, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Lisa S. Grant	22. NAME AND ADDRESS OF FACILITY: Fort Lincoln Funeral Home, Inc. 3401 Bladensburg Rd., Brentwood, MD 20722		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. HYPERTENSION DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: pulmonary edema, Diabetes mellitus

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [X] NO [ ] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: J Berger MD	29c. LICENSE NUMBER: D25925	29d. DATE SIGNED (Month, Day, Year): June 12, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. BERGER MD #205, 7720 Wisconsin Ave, Bethesda, Md 20814		
31. DATE FILED (Month, Day, Year): JUN 16 1995	32. REGISTRAR'S SIGNATURE: Julia Thurston-Randall	

DHMH-18 Rev 1/89

6

1 of 1

95 20221

4

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Eleanor Kindron Diebold
2. DATE OF DEATH (Month, Day, Year): June 19, 1995
3. TIME OF DEATH: 6:07 P M
4. SOCIAL SECURITY NUMBER: 066-38-3066
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 88 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): Feb. 4, 1907
8. BIRTHPLACE (State or Foreign Country): New York
9a. FACILITY NAME (If not institution, give street and number): Bel Forest Nursing & Rehab. Center
9b. CITY, TOWN OR LOCATION OF DEATH: Forest Hill
9c. COUNTY OF DEATH: Harford

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Harford
10c. CITY, TOWN OR LOCATION: Bel Air
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 330 Harlan Sq.
10f. ZIP CODE: 21014
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): Frank --- Kindron
18. MOTHER'S NAME (First, Middle, Maiden Surname): Olga Olive Obermiller
19a. INFORMANT'S NAME (Type/Print): Mary Jean Honecker
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 330 Harlan Sq., Bel Air, Md. 21014
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Mount Olivet Cemetery DATE 6-23-95
20c. LOCATION — City or Town, State: Kenmore, New York
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Howard K. McComas III
22. NAME AND ADDRESS OF FACILITY: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Md. 21009

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cerebrovascular Accident	3 weeks
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus.
Multi-Infarct Dementia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: J. Kevin
29c. LICENSE NUMBER: D35012
29d. DATE SIGNED (Month, Day, Year): JUNE 21, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John Kevin Lynch M.D. 2 North Ave. Bel Air, Md. 21014.
31. DATE FILED (Month, Day, Year): JUN 21 1995
32. REGISTRAR'S SIGNATURE: Julia Dawkins-Randall

OHMH-16 Rev 1/89

95 20222

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Violet Cropper DAvis			2. DATE OF DEATH (Month / Day / Year): 6 / 12 / 95	3. TIME OF DEATH: 9:35 P M
4. SOCIAL SECURITY NUMBER: 214-32-7174	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 98 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 1/1/1897	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): 607 N. Baltimore Ave.		9b. CITY, TOWN OR LOCATION OF DEATH: Ocean City		9c. COUNTY OF DEATH: Worcester
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY: Worcester	10c. CITY, TOWN OR LOCATION: Ocean City		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 607 N. Baltimore Ave.		10f. ZIP CODE: 21842		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementery/Secondery (0-12):	College (1-4 or 5+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Apartment House Owner/Operator	16b. KIND OF BUSINESS/INDUSTRY: Tourism	
17. FATHER'S NAME (First, Middle, Last): Thomas J. Cropper		18. MOTHER'S NAME (First, Middle, Maiden Surname): Sallie Hastings		
19a. INFORMANT'S NAME (Type/Print): Art Davis		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10806 Piney Island Dr. Bishopville, MD 21813		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Cape Henlopen Crematory DATE: 6/13/95	20c. LOCATION — City or Town, State: Frankford, DE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ W. Fred Burbage		22. NAME AND ADDRESS OF FACILITY: Burbage Funeral Home 108 Williams St. Berlin, MD 21811		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter tha mode of dying, such ae cerdiac or reepiratory arrest, ehock, or heart feliure. List only one ceuse on eech line.

		Approximate interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition resulting in daath) →	a. CNS	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentielly liat conditions, if any, leeding to immediete ceuse. Enter UNDERLYING CAUSE (Diseese or injury thet initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	OUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART ii. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

28. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
	M24917	▶ 6/14/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RC Hudson Akron MD

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 14 1995	Julia Bindon-Randall

DHMH-16 Rev 1/89

95 20223

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GEORGE KENNEDY DULANEY			2. DATE OF DEATH (Month, Day, Year): June 18, 1995	3. TIME OF DEATH: 7:50 a M
4. SOCIAL SECURITY NUMBER: 215-10-0809	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 79 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 10/30/1915	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 801 Coconut Court		9b. CITY, TOWN OR LOCATION OF DEATH: Bel Air	9c. COUNTY OF DEATH: Harford	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Bel Air	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 801 Coconut Court Apt. A	10f. ZIP CODE: 21014	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEOENT EVER IN U.S. ARMEO FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Caucasian

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Mechanical Engineer	16b. KIND OF BUSINESS/INDUSTRY: Communications tubing	
17. FATHER'S NAME (First, Middle, Last): Henry Stier Dulaney		18. MOTHER'S NAME (First, Middle, Maiden Surname): Helen Barnard	
19a. INFORMANT'S NAME (Type/Print): Louise S. Dulaney	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as #10		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Carroll Cremation	20c. LOCATION — City or Town, State: Hampstead, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ W. Kleindienst Kurtz III	22. NAME AND ADDRESS OF FACILITY: Kurtz Funeral Home Jarrettsville, Maryland		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Arrythmia	hours
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.		
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

parkinson's disease

Normal pressure hydrocephalus

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D28136	29d. DATE SIGNED (Month, Day, Year): ▶ 6-19-95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		
31. DATE FILED (Month, Day, Year): JUN 19 1995	32. REGISTRAR'S SIGNATURE: Gabi Kleindienst Randall	

DHMH-16 Rev 1/89

95 20224

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Sadie Elizabeth Day
2. DATE OF DEATH (Month, Day, Year): June 17, 1995
3. TIME OF DEATH: 10:20 A.M
4. SOCIAL SECURITY NUMBER: 217-28-7161
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 94 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Feb. 18, 1901
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Frederick
9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Frederick
10c. CITY, TOWN OR LOCATION: Mount Airy
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 13819 Penn Shop Road
10f. ZIP CODE: 21771
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4 or 5+):
16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Own home.
17. FATHER'S NAME (First, Middle, Last): Collie Martin Gue
18. MOTHER'S NAME (First, Middle, Maiden Surname): Hattie Mae Ridgley
19a. INFORMANT'S NAME (Type/Print): Quentin L. Day
19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13819 Penn Shop Rd., Mount Airy, Maryland 21771
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Providence Cemetery — DATE: 6/21
20c. LOCATION — City or Town, State: Kemptown, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Olin L. Molesworth
22. NAME AND AOORESS OF FACILITY: Olin L. Molesworth, P.A., Funeral Home, 26401 Ridge Road, Damascus, Maryland

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CORONARY ARTERY DISEASE — several years

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ASTHMA -

PARKINSON'S DISEASE

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: David B. Harding MD
29c. LICENSE NUMBER: D35965
29d. DATE SIGNED (Month, Day, Year): June 18, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DAVID B. HARDING, M.D. 1001 Twin Arch Rd., Mount Airy, Maryland 21771

31. DATE FILED (Month, Day, Year): JUN 21 1995
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

95 20225

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JAMES Raleigh DAVIS			2. DATE OF DEATH: MONTH JUNE DAY 12 YEAR 1995	3. TIME OF DEATH: 9-45 P M
4. SOCIAL SECURITY NUMBER: 298-16-3086	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 83 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): July 16, 1911	8. BIRTHPLACE (State or Foreign Country): Ohio
9a. FACILITY NAME (If not institution, give street and number): SOUTHERN MARYLAND HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: CLINTON		9c. COUNTY OF DEATH: PRINCE GEORGES

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Prince George's	Clinton	1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
8912 Marquis Lane	20735	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES?	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	1 [ ] YES 2 [X] NO Specify:	Specify: Caucasian

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12): 8th	College (1-4 or 5+): N/A	Farmer	Self-Employed

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
William Rhine Davis	Bertha Arminta Titus

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Douglas Davis Sr.	8912 Marquis Lane Clinton, Maryland 20735

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Pearl Cemetery	June 16, 1995	Swanders Ohio

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ J. Bates	Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, Md 20735

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Enterococcal fecalis Bacteremia	7 day
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF): Septic shock (Hypotension)	7 days
	c. DUE TO (OR AS A CONSEQUENCE OF): Renal Failure	7 Days
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [ ] YES 2 [✓] NO	HOSPITAL: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined		M	1 [ ] YES 2 [ ] NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
M.D Attending	D-24535	▶ 13 June 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
LAXMI BERWA 7700 OLD BRANCH AVENUE CLINTON MARYLAND 20735

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 20 1995	Julia Davidson-Randall

OHMH-16 Rev 1/89

95 20226

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Charles GORDON DUNNING			2. DATE OF DEATH (Month, Day, Year): Jun 23 1995	3. TIME OF DEATH: 4:45 pm M
4. SOCIAL SECURITY NUMBER: 186-03-2911	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 80 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Aug. 25, 1914
8. BIRTHPLACE (State or Foreign Country): Maryland				
9a. FACILITY NAME (If not institution, give street and number): Saint Joseph Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH: Towson, Maryland		9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Freeland	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 19821 Gore Mill Road		10f. ZIP CODE: 21053	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Electrician	16b. KIND OF BUSINESS/INDUSTRY: Communication	
17. FATHER'S NAME (First, Middle, Last): Robert Dunning		18. MOTHER'S NAME (First, Middle, Maiden Surname): Sarah Hartman	
19a. INFORMANT'S NAME (Type/Print): Robert C. Dunning	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 20633 Slab Bridge Rd., Freeland, Md. 21053		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Yorktowne Casket Creamtion Ser. DATE: 6/27/95	20c. LOCATION — City or Town, State: York, Pa.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Karen D. Seibert	22. NAME AND ADDRESS OF FACILITY: J.J.Hartenstein Mortuary 24 Second St., New Freedom, Pa. 17349		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. THROMBOEMBOLIC STROKE RIGHT CEREBELLUM	2 WEEKS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. POSSIBLE HEMORRHAGIC STROKE	3 DAYS
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ASPIRATION PNEUMONIA

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

	24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	26a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY M	26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	26d. DESCRIBE HOW INJURY OCCURED
	26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD	29c. LICENSE NUMBER: D 18822	29d. DATE SIGNED (Month, Day, Year): ▶

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
RICHARD HABERSAT, M.D., 214 MOUNT CARMEL ROAD PARKTON,MARYLAND 21120

31. DATE FILED (Month, Day, Year): JUN 29 1995	32. REGISTRAR'S SIGNATURE: Julia Strother Kardell

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 20227

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CAROLYN A. EDMUNDS			2. DATE OF DEATH (Month, Day, Year): June 10, 1995	3. TIME OF DEATH: 842P M
4. SOCIAL SECURITY NUMBER: 577-56-6551	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 49 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 11-19-1945	8. BIRTHPLACE (State or Foreign Country): Washington, DC
9a. FACILITY NAME (If not institution, give street and number): Bowie Health Care Center		9b. CITY, TOWN OR LOCATION OF DEATH: Bowie		9c. COUNTY OF DEATH: Prince George's

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Temple Hills	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 4311 23rd Parkway, #306		10f. ZIP CODE: 20748	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Collection Agent	18b. KIND OF BUSINESS/INDUSTRY: Government	
17. FATHER'S NAME (First, Middle, Last): Unknown		18. MOTHER'S NAME (First, Middle, Maiden Surname): Lena Williams	
19a. INFORMANT'S NAME (Type/Print): Joel McDuffie/Daughter	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5325 Astor Place, S.E., #3, Washington, DC 20019		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Glenwood Cemetery; DATE: 6/15/1995	20c. LOCATION — City or Town, State: Washington, D.C.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Shawana L. Braxton	22. NAME AND ADDRESS OF FACILITY: J.B. JENKINS FUNERAL HOME 7474 Landover Rd., Landover, MD 20785		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Hypertensive atherosclerotic cardiovascular disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

None

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☑

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☑ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Augusto P. Rodriguez MD	29c. LICENSE NUMBER: D21730	29d. DATE SIGNED (Month, Day, Year): June 12, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Augusto P. Rodriguez MD, 5009 Roycroft Ct. Upper Marlboro MD 20748		
31. DATE FILED (Month, Day, Year): JUN 15 1995	32. REGISTRAR'S SIGNATURE: Julia Hamilton-Randall	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

9

95 20228

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EVELYN CHRISTINE EATON			2. DATE OF DEATH (Month, Day, Year): JUNE 19, 1995	3. TIME OF DEATH: 3:25 A M
4. SOCIAL SECURITY NUMBER: 579-40-0997	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 63 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): MAY 10, 1932	8. BIRTHPLACE (State or Foreign Country): WASHINGTON DC
9a. FACILITY NAME (If not institution, give street and number): 1213 BANNISTER CIRCLE		9b. CITY, TOWN OR LOCATION OF DEATH: WALDORF		9c. COUNTY OF DEATH: CHARLES
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: CHARLES	10c. CITY, TOWN OR LOCATION: WALDORF		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1213 BANNISTER CIRCLE		10f. ZIP CODE: 20602		10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): WAITRESS	16b. KIND OF BUSINESS/INDUSTRY: RESTAURANT		
17. FATHER'S NAME (First, Middle, Last): GEORGE E. BOWLEY		18. MOTHER'S NAME (First, Middle, Maiden Surname): EVELYN MARIE REED		
19a. INFORMANT'S NAME (Type/Print): VICKI L. HASSON		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1213 BANNISTER CIRCLE, WALDORF, MARYLAND 20602		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery, Crematory or Other Place): WASHINGTON NATIONAL CEM.	DATE: 06-21-95	20c. LOCATION — City or Town, State: SUITLAND, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: MGR ▶ Mark G. Brohawn MARK G. BROHAWN M00053		22. NAME AND ADDRESS OF FACILITY: THE HUNTT FUNERAL HOME, INC. P.O.BOX 156, WALDORF, MARYLAND 20604		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cancer Esophagus DUE TO (OR AS A CONSEQUENCE OF):	5mo
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

28. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Thomas L Fieldson MD	29c. LICENSE NUMBER: D01925	29d. DATE SIGNED (Month, Day, Year) ▶ JUNE 19, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): THOMAS L. FIELDSON, M.D., BRANDYWINE WALDORF CLINIC, BRANDYWINE, MD. 20613-5907

31. DATE FILED (Month, Day, Year): JUN 21 1995	32. REGISTRAR'S SIGNATURE: Julia Thomson-Randall

DHMH-16 Rev 1/89

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95 20229

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JANET LYNN EWING			2. DATE OF DEATH (Month, Day, Year): JUNE 17 1995	3. TIME OF DEATH: 7:45 PM
4. SOCIAL SECURITY NUMBER: 214-88-6435	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 34 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): DEC 26 1960	8. BIRTHPLACE (State or Foreign Country): Baltimore MD
9a. FACILITY NAME (If not institution, give street and number): HARFORD MEMORIAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: HAVRE de GRACE		9c. COUNTY OF DEATH: HARFORD
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY: Cecil	10c. CITY, TOWN OR LOCATION: Rising Sun		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 11 Spring House Crt		10f. ZIP CODE: 21911		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Home		
17. FATHER'S NAME (First, Middle, Last): Joseph R. Shifflett, Jr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Jacqueline Messinger		
19a. INFORMANT'S NAME (Type/Print): Richard O. Ewing, Jr.	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11 Spring House Crt Rising Sun MD 21911			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Harford Memorial Garde	DATE: 6-21-1995	20c. LOCATION — City or Town, State: Abeerdeen, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶	22. NAME AND ADDRESS OF FACILITY: R. T. Foard Funeral Home, P.A. 111 S Queen St Rising Sun MD 21911			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Multiple Injuries	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 6/17/95	28b. TIME OF INJURY: 7:15 PM	28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO
	28d. DESCRIBE HOW INJURY OCCURED: Subject operator of Jetski Struck Jetski		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): water	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Port Deposit water near Marylan	

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Theodore M. King MD	29c. LICENSE NUMBER: O.C.M.E.	29d. DATE SIGNED (Month, Day, Year): ▶ JUNE 18, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): THEODORE M. KING MD	111 Penn Street, Baltimore, Maryland 21201	
31. DATE FILED (Month, Day, Year): JUN 20 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall	

DHMH-18 Rev 1/89

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95 20230

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Vernon Le FREE			2. DATE OF DEATH (Month, Day, Year): 6 7 95	3. TIME OF DEATH: 8:30p M
4. SOCIAL SECURITY NUMBER: 577-76-1778	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 39 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 11/19/56	8. BIRTHPLACE (State or Foreign Country): Wash. D.C.
9a. FACILITY NAME (If not institution, give street and number): Hyattsville Manor		9b. CITY, TOWN OR LOCATION OF DEATH: Hyattsville		9c. COUNTY OF DEATH: P.G.

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: P.G.	10c. CITY, TOWN OR LOCATION: Hyattsville	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 6500 Riggs Rd.		10f. ZIP CODE: 20780	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Duplicator	16b. KIND OF BUSINESS/INDUSTRY: Private Industry	
17. FATHER'S NAME (First, Middle, Last): Joe May		18. MOTHER'S NAME (First, Middle, Maiden Surname): Doris Free	
19a. INFORMANT'S NAME (Type/Print): Diane Ray		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3489 Summitt Ct.,N.E.,Washington,D.C.	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Harmony Memorial Pk. DATE: 6/13/95	20c. LOCATION — City or Town, State: Landover, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ W. J. Jeffers		22. NAME AND ADDRESS OF FACILITY: Frazier Funeral Home 389 Rhode Island Av.,NW, Washington,D.C.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	ACQUIRED IMMUNE DEFICIENCY SYNDROME	UNKNOWN
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	CELLULITIS OF LEFT FOOT	UNKNOWN
DUE TO (OR AS A CONSEQUENCE OF):		
c.	PNEUMONIA	UNKNOWN
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: ANEMIA, LEUKOPENIA, WASTING SYNDROME

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☒ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D01499	29d. DATE SIGNED (Month, Day, Year): ▶ June 12, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): LEWIS HILLIARD DENNIS M.D., P.A. 6201 GREENBELT RD #U-1 COLLEGE PARK, MD 20740

31. DATE FILED (Month, Day, Year): JUN 16 1995	32. REGISTRAR'S SIGNATURE: Julia Dawkins Randall

(2)

DHMH-16 Rev 1/89

95 20231

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BEATRICE C. FREEMAN
2. DATE OF DEATH (Month, Day, Year): June 9 1995
3. TIME OF DEATH: 1:20 p M
4. SOCIAL SECURITY NUMBER: 243-32-6248
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 78 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): March 18, 1917
8. BIRTHPLACE (State or Foreign Country): North Carolina
9a. FACILITY NAME (If not institution, give street and number): Southern Maryland Hospital Center
9b. CITY, TOWN OR LOCATION OF DEATH: Clinton
9c. COUNTY OF DEATH: Prince Georges

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Prince Georges
10c. CITY, TOWN OR LOCATION: Temple Hills
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2709 Fairlawn Street
10f. ZIP CODE: 20748
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5 +): 4
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher
16b. KIND OF BUSINESS/INDUSTRY: D.C. PUBLIC SCHOOLS
17. FATHER'S NAME (First, Middle, Last): Louis Crowder
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mollie Carr
19a. INFORMANT'S NAME (Type/Print): Rhonda Freeman
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3846-26th Avenue, Temple Hills, MD 20748
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Lincoln Mem. Cemetery DATE: 6/13
20c. LOCATION — City or Town, State: Suitland, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ J.P. Marshall
22. NAME AND ADDRESS OF FACILITY: Marshall's Funeral Home, Inc. 4308 Suitland Rd. Suitland, MD 20746

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Myocardial infarction	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Complete heart block	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Coronary heart disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☑ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M Talegani M.D.
29c. LICENSE NUMBER: D-10868
29d. DATE SIGNED (Month, Day, Year): ▶ 6-10-95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mohammad Tale Ghani 4467 Old Branch AVE #301 Temple Hills MD

31. DATE FILED (Month, Day, Year): JUN 14 1995
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

18
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DHMH-18 Rev 1/89

95 20232

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MASCO FOWLER			2. DATE OF DEATH (Month, Day, Year): 6 10 95	3. TIME OF DEATH: 2:55 pm M
4. SOCIAL SECURITY NUMBER: 148 14 5652	5. SEX: 1 ☑ M 2 ☐ F	6. AGE (In yrs. last birthday): 69 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Nov. 11, 1925	8. BIRTHPLACE (State or Foreign Country): Greenville, S.C.
9a. FACILITY NAME (If not institution, give street and number): Athey Woodland Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring Md		9c. COUNTY OF DEATH: P.G.

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Virginia	Fairfax	Alexandria	1 ☐ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
6822 Lamp Post Lane	22306	United States

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES?	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: yes	1 ☐ YES 2 ☒ NO Specify:	Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12): 8	College (1-4 or 5+):	Retired Federal Employee	Gov.

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Melvin C. Fowler	Merlin Locke

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Melvin C Fowler, Sr.	6822 Lamp Post Lane Alexandria, va.

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Mt. Comfort	6/17/95	Alexandria, Virginia

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ John T. Stewart III	Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cerebral vascular accident. DUE TO (OR AS A CONSEQUENCE OF):	Weeks
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Insulin dependent diabetes mellitus

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
1 ☐ YES 2 ☒ NO	

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Jung-pz Lee MD	D26707	▶ 6-12-95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
TUNG-PZ LEE, MD 700 Buckingham Dr. Silver Spring MD 20901

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 16 1995	Julia Davidson-Randall

3

DHMH-18 Rev 1/89

95 20233

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DONALD COOK FINNEY			2. DATE OF DEATH (Month, Day, Year): June 13 1995	3. TIME OF DEATH: 12 10/A M
4. SOCIAL SECURITY NUMBER: 215-32-4670	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 60 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Aug. 19,1934	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Stella Maris Hospice		9b. CITY, TOWN OR LOCATION OF DEATH: Towson	9c. COUNTY OF DEATH: Baltimore	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Bel Air	10d. INSIDE CITY LIMITS? [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 310 Williams St.		10f. ZIP CODE: 21014	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: 1957 - 1959	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Master Electrician	16b. KIND OF BUSINESS/INDUSTRY: Electrical	
17. FATHER'S NAME (First, Middle, Last): William Oliver Finney		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ruth Evelyn Pyle	
19a. INFORMANT'S NAME (Type/Print): Doris C. Finney	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 310 Williams St., Bel Air, Md. 21014		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place): Churchville Presb. Cemetery DATE: 6-16-95	20c. LOCATION — City or Town, State: Churchville, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Stephen A Hughes	22. NAME AND ADDRESS OF FACILITY: Howard K. McComas III Funeral Home, P.A. 50 W. Broadway St., Bel Air, Md. 21014		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. SMALL CELL LUNG CANCER	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [X]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [X] Other (Specify): Hospice	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Kendall R Faulkners	29c. LICENSE NUMBER: D25643	29d. DATE SIGNED (Month, Day, Year): 6/13/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204

31. DATE FILED (Month, Day, Year): JUN 15 1995	32. REGISTRAR'S SIGNATURE: Julia Strecker Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 20234

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ruth (NMN) Forth		2. DATE OF DEATH (Month, Day, Year): June 16, 1995	3. TIME OF DEATH: 7:30 P. M
4. SOCIAL SECURITY NUMBER: 084-24-1705	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 71 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Sept. 3, 1923
8. BIRTHPLACE (State or Foreign Country): New York			
9a. FACILITY NAME (If not institution, give street and number): 3888 Shadywood Dr.	9b. CITY, TOWN OR LOCATION OF DEATH: Jefferson	9c. COUNTY OF DEATH: Frederick	
RESIDENCE OF DECEDENT			
10a. STATE: Md.	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Jefferson	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3888 Shadywood Dr.		10f. ZIP CODE: 21755	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 3; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): homemaker	16b. KIND OF BUSINESS/INDUSTRY: own home	
17. FATHER'S NAME (First, Middle, Last): Joseph Hines		18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Unknown	
19a. INFORMANT'S NAME (Type/Print): George W. Forth Jr.	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3888 Shadywood Dr., Jefferson, Md. 21755		
20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Reshaven Memorial Gardens	DATE: 6/21	20c. LOCATION — City or Town, State: Frederick, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald B Thompson	22. NAME AND ADDRESS OF FACILITY: Donald B. Thompson Funeral Home 31 E. Main St., Middletown, Md. 21769		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. metastatic Colon carcinoma	10 mo
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D14626	29d. DATE SIGNED (Month, Day, Year): June 19, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): D G Nauck 501 W Second St Frederick MD 21701		
31. DATE FILED (Month, Day, Year): JUN 21 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

95 20235

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
Vera	Amy	FREDERICKS	June 16, 1995	11:21 am M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
080-01-2538	1 ☐ M 2 ☒ F	77 YRS.			July 16, 1917	New York

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Frederick Memorial Hospital	Frederick	Frederick

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
New York	Rockland	Hillbern	1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
Second Street	10931	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5 +)		
12		Production Operator	Avon Products

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
John STEAD	Hilda MILLER

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Gary Fredericks	6220 White Oak Drive, Frederick, Maryland 21701

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)	Evergreen Cemetery	Jun 21, 1995	Airmont, New York

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
Kathryn Robersen M00706	Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, MD 21701

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiac Arrhythmia	≈ 5 minutes
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. prostate hypertrophic hypertrophy	≈ 30 minutes
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Atherosclerotic Cardiovascular disease	over 5 years
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Arthur G. Manalo, M.D.	D18191	June 16, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Arthur G. Manalo, M.D., 187 Thomas Johnson Drive, Frederick, Maryland 21702

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 19 1995	Julia Davidson Randall

DNMH-16 Rev 1/89

95 20236

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Charles F. Godfrey			2. DATE OF DEATH (Month, Day, Year): June 14, 1995	3. TIME OF DEATH: 6:54 PM
4. SOCIAL SECURITY NUMBER: 212-38-3900	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 54 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): November 11, 1940	8. BIRTHPLACE (State or Foreign Country): Washington, DC
9a. FACILITY NAME (If not institution, give street and number): FREDERICK MEMORIAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: FREDERICK		9c. COUNTY OF DEATH: FREDERICK

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Germantown	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 12217 Thorn Grove Place		10f. ZIP CODE: 20874	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — Americen Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Firemen	16b. KIND OF BUSINESS/INDUSTRY: D.C. Fire Department	
17. FATHER'S NAME (First, Middle, Last): William L. Godfrey		18. MOTHER'S NAME (First, Middle, Maiden Surname): Sadie Milburn	
19a. INFORMANT'S NAME (Type/Print): Georgia Godfrey		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12217 Thorn Grove Place, Germantown, MD 20874	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Lakemont Memorial Gardens	DATE: 6/19/95	20c. LOCATION — City or Town, State: Davidsonville, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Richard Rendon		22. NAME AND ADDRESS OF FACILITY: Rendon/Hale Lanham Funeral Home 9013 Annapolis Road, Lanham, MD 20706	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	MONTHS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [X]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end manner ee stated.
2 [X] MEDICAL EXAMINER: On the beele of exemination end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(s) end manner ee stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Robert R Roberts MD	29c. LICENSE NUMBER: D09867	29d. DATE SIGNED (Month, Day, Year): June 14 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): R R ROBERTS MD 15 W 7TH ST FREDERICK MD 21701-4599		
31. DATE FILED (Month, Day, Year): JUN 16 1995	32. REGISTRAR'S SIGNATURE: Julia Blanchard-Randall	

(10)

DHMH-18 Rev 1/89

95 20237

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MYRTLE J. GREEN			2. DATE OF DEATH Month: 6 Day: 11 Year: 95	3. TIME OF DEATH: 7 P M
4. SOCIAL SECURITY NUMBER: 216-30-4255	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 63 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Feb. 2, 1932	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Silver Spring	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1001 Spring St. #1105		10f. ZIP CODE: 20910	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 12th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Waitress	16b. KIND OF BUSINESS/INDUSTRY: Unknown	
17. FATHER'S NAME (First, Middle, Last): Frank Jones Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Pearl Strickland	
19a. INFORMANT'S NAME (Type/Print): Iris Carter	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1001 Spring St. #1105 Silver Spring, MD 20910		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place): Metropolitan Crematory	DATE: 6-13	20c. LOCATION — City or Town, State: Alexandria, VA.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: J. P. Marshall	22. NAME AND ADDRESS OF FACILITY: Marshall's Funeral Home 4217 9th St. NW Washington, D.C. 20011		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardio Pulmonary Arrest	Sudden
DUE TO (OR AS A CONSEQUENCE OF): b.	Respiratory failure	Sudden
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	Congestive heart failure	months
DUE TO (OR AS A CONSEQUENCE OF): d.	Renal failure	years

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus
Sepsis

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: SK Gupta MD	29c. LICENSE NUMBER: D-32332	29d. DATE SIGNED (Month, Day, Year): 06/12/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 9801 Georgia Ave # 220 Silver Spring, Md 20902		
31. DATE FILED (Month, Day, Year): JUN 14 1995	32. REGISTRAR'S SIGNATURE: [illegible]	

DHMH-18 Rev 1/89

95 20238

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Carolyn Estella Graham				2. DATE OF DEATH (Month, Day, Year): June 12, 1995	3. TIME OF DEATH: 8:15A M
4. SOCIAL SECURITY NUMBER: 064-48-9063	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 38 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): AUG. 27, 1956
8. BIRTHPLACE (State or Foreign Country): SOUTH CAROLINA					
9a. FACILITY NAME (If not institution, give street and number): DOCTORS COMMUNITY HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: LANHAM		9c. COUNTY OF DEATH: PRINCE GEORGE'S	
RESIDENCE OF DECEDENT					
10a. STATE: MARYLAND	10b. COUNTY: PRINCE GEORGE'S	10c. CITY, TOWN OR LOCATION: NEW CARROLLTON		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER: 7609 RIVERDALE ROAD #326		10f. ZIP CODE: 20784		10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 1 YR.	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DATA PROCESSOR		16b. KIND OF BUSINESS/INDUSTRY: PVT.	
17. FATHER'S NAME (First, Middle, Last): JOSEPH GRAHAM		18. MOTHER'S NAME (First, Middle, Maiden Surname): BETHENIA BROCK			
19a. INFORMANT'S NAME (Type/Print): CURTIS WASHINGTON		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7609 RIVERDALE RD. #326 NEW CARROLLTON, MD 20784			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): MD VETERANS CEMETERY	DATE: 6-16-95	20c. LOCATION — City or Town, State: CHELTENHAM, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Shawana L. Braxton		22. NAME AND ADDRESS OF FACILITY: J.B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MD 20785			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Sepsis	1 day
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Pneumonia	1 day
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Acquired Immune Deficiency Syndrome	years
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☑ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Frederick H Wilhelm, MD	D10220	▶ June 13, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Frederick Wilhelm 5807 Annapolis Road Hyattsville, MD 20784

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 15 1995	Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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95-3427-009
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95 20239

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WANDA ANN GRAHAM			2. DATE OF DEATH (Month, Day, Year): JUNE 11 1995	3. TIME OF DEATH: 9:30 PM
4. SOCIAL SECURITY NUMBER: 213-78-4111	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 35 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Jan. 28, 1960	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 12940 ROUSBY HALL ROAD		9b. CITY, TOWN OR LOCATION OF DEATH: LUSBY	9c. COUNTY OF DEATH: CALVERT	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Calvert	10c. CITY, TOWN OR LOCATION: Lusby	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 12940 Rousby Hall Rd.		10f. ZIP CODE: 20657	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cook	16b. KIND OF BUSINESS/INDUSTRY: Restaurant	
17. FATHER'S NAME (First, Middle, Last): Nathaniel Buck, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Frances Stewart	
19a. INFORMANT'S NAME (Type/Print): Violet Buck	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 302 Lusby, MD 20657		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Eastern UM Chr. Cem. DATE: 6/17/95	20c. LOCATION — City or Town, State: Lusby, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Spencer E. Sewell	22. NAME AND ADDRESS OF FACILITY: Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. GUNSHOT WOUNDS TO HEAD AND CHEST	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☒ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 6/11/95	28b. TIME OF INJURY: 8:30 PM	28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO
	28d. DESCRIBE HOW INJURY OCCURED: SUBJECT SHOT		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): HOME	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 12940 ROUSBY HALL ROAD	

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: O.C.M.E.	29d. DATE SIGNED (Month, Day, Year): JUNE 12, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DAVID R FOWLER	111 Penn Street, Baltimore, Maryland 21201	
31. DATE FILED (Month, Day, Year): JUN 16 1995	32. REGISTRAR'S SIGNATURE: Julia Henderson-Randall	

3

DHMH-16 Rev 1/89

95-3307-009
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95 20240

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mark Lane Gribble		2. DATE OF DEATH: MONTH June DAY 05 YEAR 1995	3. TIME OF DEATH: 1500 M
4. SOCIAL SECURITY NUMBER: 218 66 7793	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 40 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): July 26 1954
8. BIRTHPLACE (State or Foreign Country): Washington DC			
9a. FACILITY NAME (If not institution, give street and number): 14458 Solomons Island Road	9b. CITY, TOWN OR LOCATION OF DEATH: Solomons	9c. COUNTY OF DEATH: Calvert	
RESIDENCE OF DECEDENT			
10a. STATE: Maryland	10b. COUNTY: Calvert	10c. CITY, TOWN OR LOCATION: Lusby	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 13109 River Terrace	10f. ZIP CODE: 20657	10g. CITIZEN OF WHAT COUNTRY?: United States	
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indien, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10 College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): well driller	16b. KIND OF BUSINESS/INDUSTRY: Calvert Well Drilling	
17. FATNER'S NAME (First, Middle, Last): Joseph H. Gribble	18. MOTNER'S NAME (First, Middle, Meiden Surname): Carol Elaine Kaples		
19a. INFORMANT'S NAME (Type/Print): Joseph H. Gribble	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13109 River Terrace Lusby Maryland 20657		
20a. METNOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan Funeral Service DATE: June 6, 1995	20c. LOCATION — City or Town, State: Alexandria Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ BRausch	22. NAME AND ADDRESS OF FACILITY: Rausch Funeral Home 4405 Broomes Is. Rd. Port REpublic Maryland		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Dasth

IMMEDIATE CAUSE (Finel diseese or condition resulting in death) → a. Acute Ethanol and Narcotic Intoxication

DUE TO (OR AS A CONSEQUENCE OF):

Sequentielly list conditions, if any, leading to immediate csuse. Enter UNDERLYING CAUSE (Disease or injury thet initieted events resulting in desth) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? [X] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [X] Could not be determined

28a. DATE OF INJURY (Month, Day, Year): found 6-5-95

28b. TIME OF INJURY: at 3:10P

28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO

28d. DESCRIBE HOW INJURY OCCURED: unknown

28e. PLACE OF INJURY — At home, ferm, street, tectory, office building, etc. (Specify): found at home

28f. LOCATION (Street end Number or Rural Route Number, City or Town, State): 14458 Solomons Island Rd., Solomons, Md.

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(a) end menner ee stated.
2 [X] MEDICAL EXAMINER: On the besis of exemination and/or investigation, in my opinion, death occured at the time, date end piece, and due to the ceuse(a) end menner ee stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Dennis J. Chute MD	O.C.M.E.	▶ June 06 1995

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print): Dennis J. Chute, MD. 111 Penn Street, Baltimore, Maryland 21201

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 20 1995	Julia Davidson-Randall

DHMH-16 Rev 1/89

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95-3426-009
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95 20241

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
ERIC	ANTHONY	GRAHAM	JUNE 11 1995	9:30 PM

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
212-78-8010	1 [X] M 2 [ ] F	37 YRS.			Apr. 21, 1958	New York

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
12940 ROUSBY HALL ROAD	LUSBY	CALVERT

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Calvert	Lusby	1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
12940 Rousby Hall Road	20657	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] YES 2 [X] NO	1 [ ] YES 2 [X] NO Specify:	Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12		Welder	Naval Base

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Warren Graham	Lorraine Gross

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Grace Graham	P.O. Box 574 Lusby, MD 20657

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	St. John UM Chr. Cem.	6/16/95	Lusby, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Spencer R. Sewell	Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. GUNSHOT WOUND OF HEAD	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [X] YES 2 [ ] NO	1 [X] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [X] YES 2 [ ] NO	HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	6/11/95	9:00PM	1 [ ] YES 2 [X] NO	SubjectsHot self

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
HOME	12940 ROUSBY HALL ROAD

29e. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
	O.C.M.E.	▶ JUNE 12,1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	
DAVID R FOWLER	111 Penn Street, Baltimore, Maryland 21201

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 16 1995	Julie Hawkins-Randall

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH-16 Rev 1/89

95 20242

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RUSSELL HARISE GILL			2. DATE OF DEATH (Month, Day, Year): June 17, 1995	3. TIME OF DEATH: 12:44 A M
4. SOCIAL SECURITY NUMBER: 183-12-4428	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 71 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): March 25, 1924	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): 1723 Churchville Rd.		9b. CITY, TOWN OR LOCATION OF DEATH: Bel Air		9c. COUNTY OF DEATH: Harford

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Bel Air	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1723 Churchville Rd.		10f. ZIP CODE: 21015	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Meat Cutter	16b. KIND OF BUSINESS/INDUSTRY: Grocery Store	
17. FATHER'S NAME (First, Middle, Last): Rush H. Gill		18. MOTHER'S NAME (First, Middle, Maiden Surname): Lenvie M. Arnold	
19a. INFORMANT'S NAME (Type/Print): Gloria L. Famous	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3633 Mill Green Rd., Street, Md. 21154		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place): Emory Methodist Cemetery	DATE: 6-20-95	20c. LOCATION — City or Town, State: Street, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Howard K. McComas III	22. NAME AND ADDRESS OF FACILITY: Howard K. McComas III Funeral Home, P.A. 50 W. Broadway St., Bel Air, Md. 21014		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic adenocarcinoma	2 mos
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Frederick W. Walker MD	29c. LICENSE NUMBER: D20463	29d. DATE SIGNED (Month, Day, Year): 6/17/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Frederick W. Walker MD, 2005 Rock Spring Rd, Forest Hill MD 21050

31. DATE FILED (Month, Day, Year): JUN 20 1995	32. REGISTRAR'S SIGNATURE: Tina Davidson Randall

DHMH-16 Rev 1/89

95 20243

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
Arthur	Lester	Gallion	June 15 1995	17.20 M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
218-12-7885	1 ☒ M 2 ☐ F	73 YRS.			Feb. 9, 1922	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
1321 Loflin Road	Aberdeen	Harford

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Harford	Aberdeen	1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
1321 Loflin Road	21001	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ☒ YES 2 ☐ NO WW II	1 ☐ YES 2 ☒ NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12	0	Laborer	County Road

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Lester G. Gallion	Minnie E. Trago

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ms. Esther E. Mann	1001 Aldino-Stepney Road, Aberdeen, MD 21001

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Baker Cemetery	6/17	Aberdeen, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
Gary R. DiGiovanni	Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Coronary Artery Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ASCVD	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

CVA

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☒ YES 2 ☐ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	NA	NA M	1 ☐ YES 2 ☒ NO	NA
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
	NA			NA

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
DME	D21809	June 15, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

G. S. Prabhu M.D. 1810 Belair Rd # 102 Fallston, MD 21047 410-879-6564

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 20 1995	Julia Davidson-Randall

DHMH-16 Rev 1/89

95 20244

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Blanche Elizabeth Green			2. DATE OF DEATH (Month, Day, Year): June 12 1995	3. TIME OF DEATH: 4:05 AM
4. SOCIAL SECURITY NUMBER: 215-20-7579	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 72 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): March 5, 1923	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Frederick	9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Thurmont	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ ND
10e. STREET AND NUMBER: 13205 Catoctin Furnace Road		10f. ZIP CODE: 21788	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ ND IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ ND Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): self	16b. KIND OF BUSINESS/INDUSTRY: homemaking	
17. FATHER'S NAME (First, Middle, Last): Edward Miller		18. MOTHER'S NAME (First, Middle, Maiden Surname): Bertie Morningstar	
19a. INFORMANT'S NAME (Type/Print): Richard Green		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13205 Catoctin Furnace Rd., Thurmont, MD 21788	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Resthaven Memorial Gardens 6/14/1995	20c. LOCATION — City or Town, State: Frederick, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Raymond Peterson		22. NAME AND ADDRESS OF FACILITY: Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute MI	minutes
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): b. CAD	
	DUE TO (OR AS A CONSEQUENCE OF): c.	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: NIDDM

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☑ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ ND	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD	29c. LICENSE NUMBER: D17549	29d. DATE SIGNED (Month, Day, Year): 6/13/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): William F. Harper, M.D. 100 So. Center St. Thurmont, Md. 21788		
31. DATE FILED (Month, Day, Year): JUN 14 1995	32. REGISTRAR'S SIGNATURE: Julia Whitmore Randall	

OHMH-18 Rev 1/89

95 20245

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Charles Francis Glass, Jr.			2. DATE OF DEATH (Month, Day, Year): June 18 1995	3. TIME OF DEATH: 7:20AM M
4. SOCIAL SECURITY NUMBER: 578-40-4154	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 83 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Nov 14 1911	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Meridian Health Care Ctr. Spa Creek		9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis		9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Annapolis	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 2818 Berth Terrace		10f. ZIP CODE: 21401	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Printer	16b. KIND OF BUSINESS/INDUSTRY: Federal Government	
17. FATHER'S NAME (First, Middle, Last): Charles Francis Glass, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Wilma Lorena Hoopes	
19a. INFORMANT'S NAME (Type/Print): Barbara G. Sullivan		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11 Copley Court Annapolis, Maryland 21403	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery	DATE: 6/21/95	20c. LOCATION — City or Town, State: Brentwood, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition resulting in death) → a.	Hemorrhagic shock	immediate
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b.	Aortic aneurysm rubture (	10days
DUE TO (OR AS A CONSEQUENCE OF): c.	Atherosclerosis	many years
DUE TO (OR AS A CONSEQUENCE OF): d.	—	—

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.: Hypertension, Non-familial polycystic kidneys, Chronic renal failure,

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X]

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Charles W. Kinzer	29c. LICENSE NUMBER: D05928	29d. DATE SIGNED (Month, Day, Year): June 18, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles W. Kinzer, MD, 1833-A Forest Drive, Annapolis, MD 21401		
31. DATE FILED (Month, Day, Year): JUN 20 1995	32. REGISTRAR'S SIGNATURE: Julia Lawrence Randall	

DHMH-1S Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 20246

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
Marjorie	Ellen	Henry	June 12, 1995	3:09 P M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
212-54-5421	1 ☐ M 2 ☒ F	43 YRS.			March 5, 1951	Washington, DC

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Physicians Memorial Hospital	La Plata	Charles

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Prince Georges	West Lanham Hills	1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
7748 Emerson Road	20784	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12		Homemaker	Own Home

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Garland Edgar Anderson	Esther Christensen

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Esther Anderson	7748 Emerson Road, West Lanham Hills, MD 20784

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Metropolitan Funeral Service	6/17/95	Alexandria, VA

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Richard Rendon	Rendon/Hale Lanham Funeral Home 9013 Annapolis Road, Lanham, MD 20706

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Self inflicted Gun shot wound to chest	instantaneous
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☒ YES 2 ☐ NO	HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☐ Natural 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	6/12/95	1500 hrs M	1 ☐ YES 2 ☒ NO	Self inflicted gun shot wound
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
	home			home

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
H.M. Hatt IV Chief Co Deputy ME	D27340	▶ 6/13/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Hatt PO Box 1647 Waldorf Md 20604

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 16 1995	Julie Director Registrar

DHMH-16 Rev 1/89

95 20247

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
BY THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
GLADYS KIRBY HOLMES		JUNE 11 1995	1000 AM

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
255-20-9247	1 ☐ M 2 ☒ F	71 YRS.			November 20, 1923	Richmond, VA

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Malcolm Grow Medical Center	Camp Springs	Prince George's

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
District	of Columbia	Washington	1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
4612 Easy Place, S.E.	20019	United States

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☒ YES 2 ☐ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
	2	Data Entry Technician	Government

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Hunter Kirby	Rosa Rose

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
William Holmes	4612 Easy Place, S.E. Wash., D.C. 20019

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Arlington National Cemetery	6/16/95	Arlington, VA

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ John T. Stewart, III	Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. NON - SMALL CELL LUNG CANCER	6 MONTHS
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
OEton MD	G7403	▶ JUNE 11, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	
OMAR ETON, MAJ, USAF, MD	89 MDG ANDREWS AIR FORCE BASE, MARYLAND 1050 W PERIMETER RD AAFB, MD 20331-6600

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 16 1995	Julie Davidson Randall

5

DHMH-16 Rev 1/89

95 20248

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MILDRED H. HODGE				2. DATE OF DEATH (Month, Day, Year): June 7 1995	3. TIME OF DEATH: 3:10 PM
4. SOCIAL SECURITY NUMBER: 216-03-9698	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 85 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): OCT. 25, 1909	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): NATIONAL LUTHERAN HOME			9b. CITY, TOWN OR LOCATION OF DEATH: ROCKVILLE		9c. COUNTY OF DEATH: MONTGOMERY CO.

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY: BALTIMORE CITY	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 6401 LOCH RAVEN BLVD.		10f. ZIP CODE: 21239	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SALES PERSON	16b. KIND OF BUSINESS/INDUSTRY: RETAIL SALES	
17. FATHER'S NAME (First, Middle, Last): LOUIS SCHURMAN		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARTHA FITZBERGER	
19a. INFORMANT'S NAME (Type/Print): REV. DR. REICHARD		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9701- VEIRS DRIVE, ROCKVILLE, MD. 20850	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): ST. JOHNS LUTH. CHURCH CEM-6	DATE: 6/13	20c. LOCATION — City or Town, State: LONG GREEN, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ W. M. Hysong		22. NAME AND ADDRESS OF FACILITY: HYSONG CO., INC. 1300- N STREET, NW. WASH., DC	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardio pulmonary arrest	immed
DUE TO (OR AS A CONSEQUENCE OF):	b. Acute cerebral vascular accident	8 hrs
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c. coronary artery disease	10 yrs
DUE TO (OR AS A CONSEQUENCE OF):	d. Chronic Obstructive Pulmonary disease	10 yrs

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Charles W. Karesh MD	29c. LICENSE NUMBER: D21726	29d. DATE SIGNED (Month, Day, Year): ▶ June 8, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. CHARLES KARESH- 9701- VEIRS DRIVE, ROCKVILLE, MD. 20850

31. DATE FILED (Month, Day, Year): JUN 12 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DHMH-16 Rev 1/89

95 20249

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
IRENE KEITH HOFFMAN			June 10, 1995	8:15 pM

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
577-74-3604	1 ☐ M 2 ☒ F	96 YRS.			Feb. 3, 1899	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Regency Nursing Home	Forestville	Prince George's

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
N/A	N/A	Washington, D.C.	1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
2031 36th Street, S.E.	20020	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12		Housewife	Own Home

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Eugene Keith	Minnie Lee Jenkins

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
H. Wayne Warner	4424 Chalfont Place, Bethesda, Maryland 20816

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Manchester Lutheran Cemetery	6/14/95	Manchester, Pennsylvania

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ W. B. Gesser	Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave.,Hyattsville, MD 20781

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. urosepsis	3days
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

congestive heart failure, dementia

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☑ NO	1 ☐ YES 2 ☑ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☑ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Vincent Chen, MD	D 38129	▶June 12, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. Vincent Chen, M.D. 9131 Piscataway Road, Suite 600, Clinton, Maryland 20735

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 13 1995	Julia Davidson-Randall

DHMH-16 Rev 1/89

Admended #6, P.G. Co, 6/19/95

95 20250

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Thomas Earl HeckStall			2. DATE OF DEATH (Month, Day, Year): June 7 95	3. TIME OF DEATH: 5:13 PM
4. SOCIAL SECURITY NUMBER: 246-62-1662	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 52 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): August 10, 1942
8. BIRTHPLACE (State or Foreign Country): North Carolina				

9a. FACILITY NAME (If not institution, give street and number): Washington Adventist Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Takoma Park	9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: West Hyattsville	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1001 Chillum Rd #419	10f. ZIP CODE: 20782	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Tractor trailer Driver	16b. KIND OF BUSINESS/INDUSTRY: Government	

17. FATHER'S NAME (First, Middle, Last): Earl Clifton Heckstall	18. MOTHER'S NAME (First, Middle, Maiden Surname): Rosella Robbins
19a. INFORMANT'S NAME (Type/Print): Clara Heckstall	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1001 Chillum Rd.#419 West Hyattsville, MD 20782

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Church Cemetery	DATE: Jun 12	20c. LOCATION — City or Town, State: Merry Hill, North Carolina
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Heart Disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John Tandan MD	29c. LICENSE NUMBER: D0854	29d. DATE SIGNED (Month, Day, Year): June 7 95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John Tandan 8218 Wisconsin Ave Bethesda		
31. DATE FILED (Month, Day, Year): JUN 13 1995	32. REGISTRAR'S SIGNATURE	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

(8)

RKD

95-3354-031

ITEMS: 23 PART I, II, 27, 28a-f, PER MEO FILM G-725 7/24/95 t.t

95 20251

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DONNA BELLE HANSON			2. DATE OF DEATH (Month, Day, Year): JUNE 7 95	3. TIME OF DEATH: 7:45 PM
4. SOCIAL SECURITY NUMBER: 460 880752	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 46 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): MAR 28,1949	8. BIRTHPLACE (State or Foreign Country): michigan
9a. FACILITY NAME (If not institution, give street and number): 12034 CENTER HILL ROAD		9b. CITY, TOWN OR LOCATION OF DEATH: WHEATON		9c. COUNTY OF DEATH: MONTGOMERY
RESIDENCE OF DECEDENT				
10a. STATE: md	10b. COUNTY: montgomery	10c. CITY, TOWN OR LOCATION: WHEATON		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 12034 CenterHill ROAD		10f. ZIP CODE: 20902		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LEGAL SECRETARY		16b. KIND OF BUSINESS/INDUSTRY: GOVERNMENT
17. FATHER'S NAME (First, Middle, Last): RICHARD HANSON			18. MOTHER'S NAME (First, Middle, Maiden Surname): BELLE DYE	
19a. INFORMANT'S NAME (Type/Print): DIANE STONE		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): DEPT OF JUSTICE P.O.BOX 7611 WASH.D.C. 20044		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place): RIVERDALE CREMATORY DATE: JUN 14,1995		20c. LOCATION — City or Town, State: RIVERDALE,MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ralph Williams		22. NAME AND ADDRESS OF FACILITY: RALPH WILLIAMS FUNERAL SVC 517 11th STREET S.E.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the dasth. Do not enter tha mode of dying, such ea cardiac or respiratory arreet, shock, or heart failure. List only ona ceuse on aach line.

Approximata Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. HEAD INJURY
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
OUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditione contributing to death but not resulting in the underlying cauee given in Pert I.
ALCOHOLISM

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEOICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF OEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)			
27. MANNER OF DEATH: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 6-7-95 FOUND	28b. TIME OF INJURY: PM	28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO	28d. DESCRIBE HOW INJURY OCCURED: SUBJECT FELL
	28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify): FOUND AT HOME			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 12034 CENTER HILL STREET WHEATON, MD.

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end menner ee stated.
2 ☒ MEOICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date end place, and due to the ceuse(s) end menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: O.C.M.E.	29d. OATE SIGNED (Month, Day, Year): ▶ JUNE 8,1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARIO F. GOLIE JR MD 111 Penn Street, Baltimore, Maryland 21201		
31. OATE FILED (Month, Day, Year): JUN 15 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

(2)

DHMH-18 Rev 1/89

95 20252

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WILL HILL			2. DATE OF DEATH (Month, Day, Year): JUNE 12, 1995	3. TIME OF DEATH: 11:15 PM M
4. SOCIAL SECURITY NUMBER: 225-38-8889	5. SEX: 1 [X] M 2 [ ] F	6. AGE (If yrs. last birthday): 62 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): MAY 20, 1933	8. BIRTHPLACE (State or Foreign Country): EMPORIA, VA
9a. FACILITY NAME (If not institution, give street and number): 2609 SOUTHERN AVENUE #101		9b. CITY, TOWN OR LOCATION OF DEATH: TEMPLE HILLS,		9c. COUNTY OF DEATH: P. G.
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: PRINCE GEORGE	10c. CITY, TOWN OR LOCATION: TEMPLE HILLS		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2609 SOUTHERN AVENUE #101		10f. ZIP CODE: 20748		10g. CITIZEN OF WHAT COUNTRY? U. S. A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10TH GRADE; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CRANE OPERATOR		16b. KIND OF BUSINESS/INDUSTRY: STEEL CO. CHICAGO, ILL.
17. FATHER'S NAME (First, Middle, Last): EDDIE LEE HILL			18. MOTHER'S NAME (First, Middle, Maiden Surname): MATTIE E. CABINESS	
19a. INFORMANT'S NAME (Type/Print): KENNETH HILL		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1930 E. 171ST STREET SO. HOLLAND, ILL. 60473		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): HARMONY MEMORIAL PARK	DATE: 6/17	20c. LOCATION — City or Town, State: LANDOVER, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Theodore C. Pinckney		22. NAME AND ADDRESS OF FACILITY: PINCKNEY-SPANGLER FUNERAL HOME 524 - 8TH ST., N. E. WASH., D. C. 20002		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	e. METASTATIC ESOPHAGEAL CANCER	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) / 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Michael S. Perna D	29c. LICENSE NUMBER: D24945	29d. DATE SIGNED (Month, Day, Year): JUNE 17, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MICHAEL S. PERNA M.D. 1328 SOUTHERN AVE SE WASHINGTON, DC 20032		
31. DATE FILED (Month, Day, Year): JUN 15 1995	32. REGISTRAR'S SIGNATURE: Galia Davidson-Randall	

DHMH-16 Rev 1/89

Amended Item 1, 6/14/95 [redacted]am Cecil Co.

95 20253

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EDNA Mae ~~MAY~~ HALsey					2. DATE OF DEATH (Month, Day, Year): June 10 1995		3. TIME OF DEATH: 1626 PM
4. SOCIAL SECURITY NUMBER: 235-34-0179	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 69 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): March 16, 1926		8. BIRTHPLACE (State or Foreign Country): West Virginia
9a. FACILITY NAME (If not institution, give street and number): 9 Pennsylvania Avenue			9b. CITY, TOWN OR LOCATION OF DEATH: Charlestown		9c. COUNTY OF DEATH: Cecil		
RESIDENCE OF DECEDENT							
10a. STATE: Maryland	10b. COUNTY: Cecil		10c. CITY, TOWN OR LOCATION: Charlestown		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO		
10e. STREET AND NUMBER: 9 Pennsylvania Avenue			10f. ZIP CODE: 21914		10g. CITIZEN OF WHAT COUNTRY?: United States		
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5 +):			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Nurses Aide		16b. KIND OF BUSINESS/INDUSTRY: Nursing Home		
17. FATHER'S NAME (First, Middle, Last): William Edward Gibson					18. MOTHER'S NAME (First, Middle, Maiden Surname): Maude J. Hoffman		
19a. INFORMANT'S NAME (Type/Print): James B. Halsey, Jr.			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9 Pennsylvania Avenue, Charlestown, MD 21914				
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Charlestown Cemetery	DATE: 6/14	20c. LOCATION — City or Town, State: Charlestown, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]			22. NAME AND ADDRESS OF FACILITY: Crouch Funeral Home 127 South Main Street, North East, MD 21901				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory Arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Emphesema	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Pneumonia	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☒ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Wanda Clemmons MD	D056674	▶ 6-10-95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Wanda J. Simmons-Clemmons MD 106 Bow Street Elkton, MD 21921

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
6-10-95	JUN 14 1995 [signature]

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10

95-3555-025
ML

3

95 20254

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
CHAD	EVERETT	HODGE	JUNE 18 1995	12:30 AM

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
216-94-9155	☒ M 2 ☐ F	15 YRS.			April 6, 1980	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
FALLSTON GENERAL HOSPITAL	FALLSTON	HARFORD

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Harford	Forest Hill	1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
1600 Denise Dr.	21050	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES?	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	1 ☐ YES 2 ☒ NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
8		Student	High School

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Wade Franklin Hodge, Sr.	Jane Olamae Testerman

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Wade F. Hodge, Sr.	1600 Denise Drive, Forest Hill, Md. 21050

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Darlington Cemetery	6-22-95	Darlington, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Stephen A. Hughes	Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Md. 21009

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Multiple injuries	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☒ YES 2 ☐ NO	1 ☒ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☒ YES 2 ☐ NO	HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	6/17/95	2215 M	1 ☐ YES 2 ☒ NO	STRUCK BY AUTO

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
STREET	HIGHWAY 24 HARFORD COUNTY MD

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Donald G. Wright MD	O.C.M.E?	▶ JUNE 18, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DONALD G. WRIGHT 111 Penn Street, Baltimore, Maryland 21201

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 20 1995	Julia Dawson-Randall

DHMH-16 Rev 1/89

95 20255

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

571

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CLYDE HAUFF				2. DATE OF DEATH (Month, Day, Year): June 15 1995	3. TIME OF DEATH: 5:35 PM
4. SOCIAL SECURITY NUMBER: 066-18-2906	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 71 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Sept. 15, 1923	8. BIRTHPLACE (State or Foreign Country): New York
9a. FACILITY NAME (If not institution, give street and number): Sinai Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH: City
RESIDENCE OF DECEDENT					
10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Towson			10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 509 E. Joppa Road			10f. ZIP CODE: 21204		10g. CITIZEN OF WNAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: WW II		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Civil Service		16b. KIND OF BUSINESS/INDUSTRY: U.S. Government	
17. FATHER'S NAME (First, Middle, Last): Clyde V. Hauff				18. MOTHER'S NAME (First, Middle, Maiden Surname): Laura J. Gordon	
19a. INFORMANT'S NAME (Type/Print): Mr. Charles Boutin			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15 South Parke Street, Aberdeen, Maryland 21001		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, cremetory or other place): R. A. Ferris & Co., Inc.	DATE: 6/17	20c. LOCATION — City or Town, State: West Chester, PA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gary R. DiGiovanni		22. NAME AND ADDRESS OF FACILITY: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Gastrointestinal Bleed	1 month
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. end Stage Renal Disease	Years
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.: Pleural Effusion, Diabetes, Parkinsons

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

28. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

26a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M Hirschbein

29c. LICENSE NUMBER: D-AS240232/MH1992

29d. DATE SIGNED (Month, Day, Year) ▶ June 15, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Marc J. Hirschbein, MD Sinai Hospital of Baltimore

31. DATE FILED (Month, Day, Year): JUN 2 0 1995

32. REGISTRAR'S SIGNATURE: Debi Booker-Randall

DHMH-16 Rev 1/89

95 20256

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mary M. Helton			2. DATE OF DEATH (Month, Day, Year): June 13, 1995	3. TIME OF DEATH: 1525 M
4. SOCIAL SECURITY NUMBER: 213-24-4429	5. SEX: 1 ☐ M 2 ☒ F	8. AGE (In yrs. last birthday): 71 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 6/11/1924	6. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: SALISBURY	9c. COUNTY OF DEATH: WICOMICO	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Worcester	10c. CITY, TOWN OR LOCATION: Pocomoke City	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 101 Fifteenth Street	10f. ZIP CODE: 21851	10g. CITIZEN OF WHAT COUNTRY?: USA	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): Robert Culp		18. MOTHER'S NAME (First, Middle, Maiden Surname): Susie Howard	
19a. INFORMANT'S NAME (Type/Print): Cecil H. Helton	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 101 Fifteenth Street, Pocomoke City, Md. 21851		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): First Baptist Cemetery; DATE: 6/16	20c. LOCATION — City or Town, State: Pocomoke City, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Scott S. Melson	22. NAME AND ADDRESS OF FACILITY: Melson Funeral Home, PO Box 64, Pocomoke City, Md. 21851		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or reapiratory arrest, shock, or heart feilure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition resulting in death) →	a. Cardiac failure	4 HR
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, lasding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Coronary artery by-pass surgery	4 HR
DUE TO (OR AS A CONSEQUENCE OF):		
	c. ? coronary artery disease	15 yr
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

Ca breast
Ca lung

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEOICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Nevin W. Todd MD	29c. LICENSE NUMBER: 11648	29d. DATE SIGNED (Month, Day, Year): 6-13-95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Nevin W. Todd, M.D. 201 Pine Bluff Road, Suite 25, Salisbury, Maryland 21801

31. DATE FILED (Month, Day, Year): JUN 19 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Rudasill

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 20257

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Garland Desmond House			2. DATE OF DEATH (Month, Day, Year): June 15, 1995	3. TIME OF DEATH: 4:45 A. M
4. SOCIAL SECURITY NUMBER: 212-14-6064	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 79 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): June 7, 1916	8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): Frederick Healthcare Center		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick		9c. COUNTY OF DEATH: Frederick
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Middletown		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 6775 Burkittsville Rd.		10f. ZIP CODE: 21769		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: W. W. II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: 11
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY: paving
17. FATHER'S NAME (First, Middle, Last): Greenbury D. House		18. MOTHER'S NAME (First, Middle, Maiden Surname): Bessie Arnold		
19a. INFORMANT'S NAME (Type/Print): Virginia I. House		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6775 Burkittsville Rd., Middletown, Md. 21769		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Lutheran Cemetery	DATE: 6/20	20c. LOCATION — City or Town, State: Middletown, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald B Thompson		22. NAME AND ADDRESS OF FACILITY: Donald B. Thompson Funeral Home 31 E. Main St., Middletown, Md. 21769		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Parkinson's Disease	3 YRS
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	ASPIRATION PNEUMONIA	1 WK
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: BENIGN PROSTATIC HYPERTROPHY, CORONARY ARTERY DISEASE

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Andrew J. Donelson MD	021936	▶ 6-19-95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 915 TOLL HOUSE #203 FREDERICK MD 21701

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 21 1995	Julia Thurston-Randall

DHMH-18 Rev 1/89

95 20258

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Norman H. Hardy			2. DATE OF DEATH (Month, Day, Year): June 14, 1995	3. TIME OF DEATH: 6:25 A. M
4. SOCIAL SECURITY NUMBER: 218-12-0397	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 90 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 23,1905	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Medbridge Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore	9c. COUNTY OF DEATH: Baltimore	
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO	
10e. STREET AND NUMBER: 6600 Ridge Road		10f. ZIP CODE: 21237	10g. CITIZEN OF WHAT COUNTRY?: United States	
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: W.W. II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Stockman	16b. KIND OF BUSINESS/INDUSTRY: Radio Corp.		
17. FATHER'S NAME (First, Middle, Last): William H. Hardy		18. MOTHER'S NAME (First, Middle, Maiden Surname): Lucy Watkins		
19a. INFORMANT'S NAME (Type/Print): Joan L. Degano		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2827 Longfellow Ct., Abington, Md. 21009		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Howard Chapel Cemetery 6/16/95	20c. LOCATION — City or Town, State: Long Corner, Md.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Olin L. Molesworth		22. NAME AND ADDRESS OF FACILITY: Olin L. Molesworth, P.A. 26401 Ridge Rd., Damascus, Md. 20872		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cancer prostate with metastasis to bone.	10 yrs.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

BRONCHITIS, Decubitus ulcer

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

26a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	D-17992	▶ June 14, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Khin M. Tun, MD. 1006 Taylot Avenue, Towson, Md. 21234

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 16 1995	[signature]

DHMH-16 Rev 1/89

95 20259

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): VIRGINIA HALL					2. DATE OF DEATH (Month, Day, Year): JUNE 15 1995	3. TIME OF DEATH: 0820 M
4. SOCIAL SECURITY NUMBER: 215-33-9366	5. SEX: 1 ☐ M 2 ☒ F XX	6. AGE (In yrs. last birthday): 52 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): OCT. 16 1942	8. BIRTHPLACE (State or Foreign Country): VIRGINIA
9a. FACILITY NAME (If not institution, give street and number): ANNE ARUNDEL MEDICAL CENTER			9b. CITY, TOWN OR LOCATION OF DEATH: ANNAPOLIS			9c. COUNTY OF DEATH: ANNE ARUNDEL

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: ANNE ARUNDEL	10c. CITY, TOWN OR LOCATION: ANNAPOLIS	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 817 SPA ROAD		10f. ZIP CODE: 21401	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE	16b. KIND OF BUSINESS/INDUSTRY: HOME	
17. FATHER'S NAME (First, Middle, Last): DAFFRON LEMON		18. MOTHER'S NAME (First, Middle, Maiden Surname): CLARA FOY	
19a. INFORMANT'S NAME (Type/Print): ARTHUR HALL	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 817 SPA ROAD ANNAPOLIS, MD. 21401		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): ST. ANNE CEMETERY DATE: 6/19/95	20c. LOCATION — City or Town, State: ANNAPOLIS, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Fanny G. Reese	22. NAME AND ADDRESS OF FACILITY: REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Ca head & neck — CANCER Head & Neck	9 mos.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☒ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D0 81 18	29d. DATE SIGNED (Month, Day, Year): ▶ 6/15/95 ST
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 900 BESTGATE RD ANNAPOLIS MD 21401		
31. DATE FILED (Month, Day, Year): JUN 20 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall	

DHMH-18 Rev 1/89

95 20260

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ESTHER IRBY			2. DATE OF DEATH (Month, Day, Year): JUNE 9 1995	3. TIME OF DEATH: 8:02 A M
4. SOCIAL SECURITY NUMBER: 578-40-8895	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 63 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Jul. 24, 1931	8. BIRTHPLACE (State or Foreign Country): WashingtonD.C
9a. FACILITY NAME (If not institution, give street and number): Prince George's Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly	9c. COUNTY OF DEATH: PRINCE GEORGE'S	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Capitol Heights	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 40 Tunic Avenue		10f. ZIP CODE: 20743	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Caterer	16b. KIND OF BUSINESS/INDUSTRY: Private	
17. FATHER'S NAME (First, Middle, Last): George Smith		18. MOTHER'S NAME (First, Middle, Maiden Surname): Alberta Washington	
19a. INFORMANT'S NAME (Type/Print): Claude C. Irby	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 40 Tunic Ave. Capital Hieghts, MD. 20743		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): harmony memrial Park DATE: Jun15	20c. LOCATION — City or Town, State: Landover,MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Shawana L. Braxton	22. NAME AND ADDRESS OF FACILITY: J.B. Jenkins Funeral Home 7474 Landover Rd. Landover,MD 20785		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. PULMONARY EDEMA / HYPOXIA	minutes
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. PULMONARY HEMORRHAGE	minutes
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. ACUTE MYOCARDIAL INFARCTION	minutes
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: obesity

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Jill Berger MD	29c. LICENSE NUMBER: D25925	29d. DATE SIGNED (Month, Day, Year): ▶ June 9, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. BERGER #205, 7720 WISCONSIN Ave Bethesda, Md 20814		
31. DATE FILED (Month, Day, Year): JUN 13 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

16

95 20261

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Catherine M. Johnson			2. DATE OF DEATH (Month, Day, Year): May 30, 1995	3. TIME OF DEATH: 9:17A M
4. SOCIAL SECURITY NUMBER: 579-20-8568	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 84 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Sept. 25, 1910	8. BIRTHPLACE (State or Foreign Country): PhiladelphiaPA
9a. FACILITY NAME (If not institution, give street and number): Southern Maryland Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Clinton	9c. COUNTY OF DEATH: Prince Georges	
RESIDENCE OF DECEDENT				
10a. STATE: D.C.	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Washington	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER: 1414 Saratoga Avenue, N.E. #1		10f. ZIP CODE: 20017	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Child Care Provider	16b. KIND OF BUSINESS/INDUSTRY: Self-employed	
17. FATHER'S NAME (First, Middle, Last): George Cook		18. MOTHER'S NAME (First, Middle, Maiden Surname): Nellie Cook		
19a. INFORMANT'S NAME (Type/Print): Catherine Brodis		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2100 Rochelle Avenue #11 Catherine Brodis District Heights, MD 20747		
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Harmony Memorial Park DATE: 6/8	20c. LOCATION — City or Town, State: Landover, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ J. P. Marshall		22. NAME AND ADDRESS OF FACILITY: Marshall's Funeral Home, Inc. 4308 Suitland Rd. Suitland, MD 20746		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory erreat, shock, or heart feilure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition resulting in death) →	a. Cardiac Arrhythmia	minutes
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST	b. Hypertensive arteriolosclerotic cardiovascular disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Infection secondary to IV for subclavian dialysis catheter	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

Severe aortic-mitral stenosis, cardiomegaly
Acute renal failure, anemia

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
August P. Rodriguez MD	D 31230	May 30, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): August P. Rodriguez MD, 5019 Raytown Ct. Cp Spr. MD 20748

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 14 1995	John Davidson Randall

OHMH-16 Rev 1/89

95 20262

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ella Mae Judkins
2. DATE OF DEATH (Month, Day, Year): June 9, 1995
3. TIME OF DEATH: 6:50am M
4. SOCIAL SECURITY NUMBER: 231-58-7932
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 80 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 5/28/15
8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): 5113 Toddsbury Place
9b. CITY, TOWN OR LOCATION OF DEATH: Forestville
9c. COUNTY OF DEATH: P.G.

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: P.G.
10c. CITY, TOWN OR LOCATION: Forestville
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 5113 Toddsbury Place
10f. ZIP CODE: 20747
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Domestic
17. FATHER'S NAME (First, Middle, Last): Willie Dobie
18. MOTHER'S NAME (First, Middle, Maiden Surname): Helen Virginia
19a. INFORMANT'S NAME (Type/Print): Catherine Allison
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5113 Toddsbury Place Forestville, Md.20747
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Washington National — DATE: 6/13/95
20c. LOCATION — City or Town, State: Suitland, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]
22. NAME AND ADDRESS OF FACILITY: Dunn & Sons 5635 Eads St. NE DC 20019

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Renal Failure

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Nephrosclerosis

DUE TO (OR AS A CONSEQUENCE OF):

c. Hypertension

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Dementia Alzheimer Type

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to tha cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Marian A. Parrott M.D.
29c. LICENSE NUMBER: 17835
29d. DATE SIGNED (Month, Day, Year) ▶ 6/9/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Marian Parrott M.D. 2150 Pann. Ave. NW #5-425 Wash. DC
31. DATE FILED (Month, Day, Year): JUN 14 1995
32. REGISTRAR'S SIGNATURE: Julia Dawkins-Randall

(5)

DHMH-16 Rev 1/89

95 20263

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARY ELEANOR JOHNSON				2. DATE OF DEATH (Month, Day, Year): June 15 1995	3. TIME OF DEATH: 2120 M
4. SOCIAL SECURITY NUMBER: 184-48-1043	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 84 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 10-8-10	8. BIRTHPLACE (State or Foreign Country): OXFORD, PA.
9a. FACILITY NAME (If not institution, give street and number): CALVERT MANOR			9b. CITY, TOWN OR LOCATION OF DEATH: RISING SUN		9c. COUNTY OF DEATH: CECIL

RESIDENCE OF DECEDENT

10a. STATE: PA.	10b. COUNTY: CHESTER	10c. CITY, TOWN OR LOCATION: OXFORD	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 401 ELECTION ROAD		10f. ZIP CODE: 19363	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSE WIFE	16b. KIND OF BUSINESS/INDUSTRY: HOMEMAKING	
17. FATHER'S NAME (First, Middle, Last): WILLIAM MAGAW		18. MOTHER'S NAME (First, Middle, Maiden Surname): MABEL GRIEST	
19a. INFORMANT'S NAME (Type/Print): HARRY CHARLES JOHNSON		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): HANCES POINT ROAD NORTHEAST, MD. 21901	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): OXFORD CEMETERY	DATE: 6/19/95	20c. LOCATION — City or Town, State: OXFORD PA. 19363
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Edward J. McCabe		22. NAME AND ADDRESS OF FACILITY: GEE FUNERAL HOME 259 EAST MAIN STREET ELKTON, MD. 21921	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CVA	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☑ NO	1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
	D.32395	▶ June 16, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Thomas Finucan Jr. Md. 3 Mauldin Avenue North East, Md.

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 19 1995	Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

NAME Johnson, Mary Eleanor

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8+ / 95 20264

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HOWARD FREDERICK JORGENSON		2. DATE OF DEATH (Month, Day, Year): June 19, 1995	3. TIME OF DEATH: 4:50 A M
4. SOCIAL SECURITY NUMBER: 468-30-5524	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 65 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Feb. 23, 1930
8. BIRTHPLACE (State or Foreign Country): Minnesota			
9a. FACILITY NAME (If not institution, give street and number): 1138 Boyd Rd.	9b. CITY, TOWN OR LOCATION OF DEATH: Street	9c. COUNTY OF DEATH: Harford	
RESIDENCE OF DECEDENT			
10a. STATE: Maryland	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Street	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1138 Boyd Rd.	10f. ZIP CODE: 21154	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: Korea	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Distributor	16b. KIND OF BUSINESS/INDUSTRY: Steel Manufacturing	
17. FATHER'S NAME (First, Middle, Last): Henry A. Jorgenson	18. MOTHER'S NAME (First, Middle, Maiden Surname): Gina --- Dyrland		
19a. INFORMANT'S NAME (Type/Print): Kathryn J. Jorgenson	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1138 Boyd Rd., Street, Md. 21154		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Emory United Methodist Cem.	DATE: 6-23-95	20c. LOCATION — City or Town, State: Street, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Stephen A. Hughes	22. NAME AND ADDRESS OF FACILITY: Howard K. McComas III Funeral Home, P.A. 50 W. Broadway St., Bel Air, Md. 21014		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Adenocarcinoma of Unknown Etiology	4 mos
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Michael Auerbach

29c. LICENSE NUMBER: D33551

29d. DATE SIGNED (Month, Day, Year): ▶ 6/19/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Michael Auerbach 9000 Franklin Sq Dr, 21237

31. DATE FILED (Month, Day, Year): JUN 20 1995

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

95 20265

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): KATHRYN MONICA JONES		2. DATE OF DEATH (Month, Day, Year): June 19, 1995	3. TIME OF DEATH: 1113A M
4. SOCIAL SECURITY NUMBER: 019223000	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 66 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 04-10-29
8. BIRTHPLACE (State or Foreign Country): Maryland			
9a. FACILITY NAME (If not institution, give street and number): Carroll County General Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Westminster	9c. COUNTY OF DEATH: Carroll County.	
RESIDENCE OF DECEDENT			
10a. STATE: Maryland	10b. COUNTY: Carroll	10c. CITY, TOWN OR LOCATION: Westminster	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 269 E. Green Street	10f. ZIP CODE: 21157	10g. CITIZEN OF WHAT COUNTRY?: United States	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): self-employed	16b. KIND OF BUSINESS/INDUSTRY: tavern	
17. FATHER'S NAME (First, Middle, Last): Estee Ray Kiser	18. MOTHER'S NAME (First, Middle, Maiden Surname): Blanche Irene Hilterbrink		
19a. INFORMANT'S NAME (Type/Print): Robert Oscar Jones	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 269 E. Green Street, Westminster, MD 21157		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place): St. Mary's Cemetery DATE: 6/22/95	20c. LOCATION — City or Town, State: Silver Run, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Katherine Pritts-Switzer	22. NAME AND ADDRESS OF FACILITY: Pritts Funeral Home & Chapel 412 Washington Rd., Westminster, MD		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ACUTE MYOCardial INFARCTION	1 week
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. SEPSIS	1 week
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. RIGHT LEG GANGRENE	1 week
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mell. DS

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending investigation 9 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Dan H. Schneidereit MD	29c. LICENSE NUMBER: D28221	29d. DATE SIGNED (Month, Day, Year): ▶ June 19, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dan H. Schneidereit, MD 200 Memorial Ave, Westminster, MD 21157		
31. DATE FILED (Month, Day, Year): JUN 21 1995	32. REGISTRAR'S SIGNATURE: Julia Thacker Randall	

DHMH-18 Rev 1/89

95 20266

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Helen Thelma Janata			2. DATE OF DEATH (Month, Day, Year): June 18, 1995	3. TIME OF DEATH: 7:30P M
4. SOCIAL SECURITY NUMBER: 577-30-2165	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 70 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Dec. 12, 1924	8. BIRTHPLACE (State or Foreign Country): Ohio
9a. FACILITY NAME (If not institution, give street and number): 4108 Beachcraft Ct.		9b. CITY, TOWN OR LOCATION OF DEATH: Temple Hills	9c. COUNTY OF DEATH: Prince George's	
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Temple Hills	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO	
10e. STREET AND NUMBER: 4108 Beachcraft Ct.		10f. ZIP CODE: 20748	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Caucasian	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5 +): N/A	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk	16b. KIND OF BUSINESS/INDUSTRY: C & P Telephone Co.		
17. FATHER'S NAME (First, Middle, Last): Benjamin Garvin	18. MOTHER'S NAME (First, Middle, Maiden Surname): Margret Blair			
19a. INFORMANT'S NAME (Type/Print): Michelle J. Hill	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1559 Sunshine Tree Blvd. Longwood Florida 32779			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): June 21, 1995 Arlington National Cemetery	20c. LOCATION — City or Town, State: Arlington Virginia		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]	22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, Md 20735			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Pancreatic Carcinoma	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☑ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: SN2448452 80	29d. DATE SIGNED (Month, Day, Year): ▶ 19 Jun 95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print):		
31. DATE FILED (Month, Day, Year): JUN 2 0 1995	32. REGISTRAR'S SIGNATURE: Julie Thrasher Randall	

DHMH-16 Rev 1/89

MARK C. STURDIVANT, MAJ, USAF, MC
244-84-5280 AFSC M4883
General Surgeon DP: 301-981-3088
89 MG, ANDREWS AFB, MD 20331-6608

BRUCE C. BURDICK, MD, USAF, MC
Colonel, Medical Corps
General Surgeon, DA
89 MDG, ANDREWS AFB, MD 20331-6000

95 20267

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARION V. JOHNSON			2. DATE OF DEATH: MONTH JUNE DAY 13 YEAR 1995	3. TIME OF DEATH: 2112 M
4. SOCIAL SECURITY NUMBER: 212-44-2179	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 52 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): JUNE 28 1942	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): ANNE ARRUNDEL MEDICAL CENTEER		9b. CITY, TOWN OR LOCATION OF DEATH: ANNAPOLIS		9c. COUNTY OF DEATH: ANNE ARUNDEL
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: ANNE ARUNDEL	10c. CITY, TOWN OR LOCATION: ANNAPOLIS		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 708 B NEWTOWN DRIVE		10f. ZIP CODE: 21401		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th; College (1-4 or 5 +): 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CASHIER SNACK BAR		16b. KIND OF BUSINESS/INDUSTRY: COMPTROLLER OF TREASURY
17. FATHER'S NAME (First, Middle, Last): PERRY CROMWELL			18. MOTHER'S NAME (First, Middle, Maiden Surname): FRANCES SMITH	
19a. INFORMANT'S NAME (Type/Print): ISAAC JOHNSON		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6803 FOREST TERRACE LANDOVER, MD. 20785		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place): ANNAPOLIS MEM. GARDENS DATE 6/16/95		20c. LOCATION — City or Town, State: ANNAPOLIS, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Larry B. Reese		22. NAME AND ADDRESS OF FACILITY: REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Ureteral Cancer	4 MONTHS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Ernest W Colvin	29c. LICENSE NUMBER: D16354	29d. DATE SIGNED (Month, Day, Year) ▶ 6/19/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 900 Bestgate Rd. #300, Annapolis, MD 21401		
31. DATE FILED (Month, Day, Year): JUN 20 1995	32. REGISTRAR'S SIGNATURE: John Davidson Randall	

DHMH-16 Rev 1/89

95 20268

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Helen Elizabeth Jones			2. DATE OF DEATH (Month, Day, Year): June 23 1995	3. TIME OF DEATH: 12:15 A M
4. SOCIAL SECURITY NUMBER: 220-32-5304	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): NOV.17,1916	8. BIRTHPLACE (State or Foreign Country): VIRGINIA
9a. FACILITY NAME (If not institution, give street and number): FREDERICK MEMORIAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: FREDERICK	9c. COUNTY OF DEATH: FREDERICK	
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: ROCKVILLE	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO	
10e. STREET AND NUMBER: 4070 NORBECK SQUARE DRIVE		10f. ZIP CODE: 20853	10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5 College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER	16b. KIND OF BUSINESS/INDUSTRY: OWN HOME		
17. FATHER'S NAME (First, Middle, Last): ROBERT ATWELL		18. MOTHER'S NAME (First, Middle, Maiden Surname): MANDIE RICH		
19a. INFORMANT'S NAME (Type/Print): MARGARET J. KNILL		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4070 NORBECK SQUARE DRIVE ROCKVILLE,MARYLAND 20853		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place): MONOCACY CEMETERY DATE: 6/27/95	20c. LOCATION — City or Town, State: BEALLSVILLE,MARYLAND		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Muriel H. Barber	22. NAME AND ADDRESS OF FACILITY: MURIEL H. BARBER FUNERAL HOME 20882 P.O. BOX 5038 LAYTONSVILLE, MARYLAND			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiac Arrhythmia	≤ 10 minutes
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Atherosclerotic Cardiovascular Disease	7 10 yrs.
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Gastrointestinal Bleeding
Dementia, Diabetes

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
	D-18191	▶ 6-23-95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. ARTHUR G. MANALO 187 THOMAS JOHNSON DRIVE FREDERICK,MARYLAND 21702

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 29 1995	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 20269

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Edna Cornelias Johnson			2. DATE OF DEATH (Month, Day, Year): June 12 1995	3. TIME OF DEATH: 1050 A M
4. SOCIAL SECURITY NUMBER: 316-24-5419	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 77 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): August 06 1917	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Harford Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Havre de Grace		9c. COUNTY OF DEATH: Harford

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Havre de Grace	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1246 Battery Drive		10f. ZIP CODE: 21078	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): housewife	16b. KIND OF BUSINESS/INDUSTRY: domestic
17. FATHER'S NAME (First, Middle, Last): Joshua Williams		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary	
19a. INFORMANT'S NAME (Type/Print): Ruby Davis		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1246 Battery Dr. Havre de Grace, MD 21078	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Union United Meth Cem DATE: 6-19	20c. LOCATION — City or Town, State: Aberdeen, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: Beard Funeral Home 552 Lewis Street Havre de Grace, Maryland 21078	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. PROBABLE CEREBRAL VASCULAR ACCIDENT	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DIABETES MELLITUS INSULIN DEPENDENT	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. CORONARY ARTERY DISEASE	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: DIABETES MELLITUS TYPE II

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Hi Sup Sim MD	29c. LICENSE NUMBER: D46412	29d. DATE SIGNED (Month, Day, Year): 6/12/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Hi Sup Sim 319 S. Union Ave Havre de Grace MD 21078		
31. DATE FILED (Month, Day, Year): JUN 15 1995	32. REGISTRAR'S SIGNATURE: [signature]	

DHMH-16 Rev 1/89

95 20270

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ROBERT FRANK KALMAN
2. DATE OF DEATH (Month, Day, Year): JUN 12 1995
3. TIME OF DEATH: 11:46 A M
4. SOCIAL SECURITY NUMBER: 286 32 1059
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 59 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): June 24 1935
8. BIRTHPLACE (State or Foreign Country): Ohio
9a. FACILITY NAME (If not institution, give street and number): NATIONAL NAVAL MEDICAL CENTER
9b. CITY, TOWN OR LOCATION OF DEATH: BETHESDA
9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Prince George's
10c. CITY, TOWN OR LOCATION: Bowie
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 12700 Crimson Court
10f. ZIP CODE: 20715
10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: Yes
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: No
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4 or 5+): 3
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Musician
16b. KIND OF BUSINESS/INDUSTRY: U.S.M.C.
17. FATHER'S NAME (First, Middle, Last): Frank Kalman
18. MOTHER'S NAME (First, Middle, Maiden Surname): Barbara Szabo
19a. INFORMANT'S NAME (Type/Print): Leora Mae Kalman
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12700 Crimson Court Bowie Md. 20715
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place): Arlington National Cemetery — DATE: 6/19/95
20c. LOCATION — City or Town, State: Arlington Virginia
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert E. Evans Pres.
22. NAME AND ADDRESS OF FACILITY: Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. PULMONARY EMBOLUS	Immediate
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. GLIOSARCOMA	14 days
DUE TO (OR AS A CONSEQUENCE OF):		
	c.	
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Michael R. Wagner MD
29c. LICENSE NUMBER: 0101-048398 (VA)
29d. DATE SIGNED (Month, Day, Year): 6/13/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MICHAEL R. WAGNER, LCDR, MC, USNR — NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600

31. DATE FILED (Month, Day, Year): JUN 16 1995
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMN-16 Rev 1/89

20
1 VA

95 20271

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RALPH JOSEPH KANE			2. DATE OF DEATH (Month, Day, Year): June 7, 1995	3. TIME OF DEATH: 9:55 A M
4. SOCIAL SECURITY NUMBER: 578-54-7850	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Aug. 27, 1913	8. BIRTHPLACE (State or Foreign Country): Washington, DC
9a. FACILITY NAME (If not institution, give street and number): 6217 61st Place		9b. CITY, TOWN OR LOCATION OF DEATH: Riverdale		9c. COUNTY OF DEATH: Prince George's
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Riverdale		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 6217 61st Place		10f. ZIP CODE: 20737		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Machinist	16b. KIND OF BUSINESS/INDUSTRY: Department of Defense		
17. FATHER'S NAME (First, Middle, Last): Edward Kane		18. MOTHER'S NAME (First, Middle, Maiden Surname): Nellie Main		
19a. INFORMANT'S NAME (Type/Print): Michael Kane	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1712 Truro Road, Crofton, Maryland 21114			
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Gate of Heaven Cemetery	DATE: 06/10/95	20c. LOCATION — City or Town, State: Silver Spring, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: W.B. Gesn	22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF):	8 years
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Hypertensive Arteriosclerotic Heart Disease DUE TO (OR AS A CONSEQUENCE OF):	15 yrs.
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	M		

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] MD	D07479	Jun 8, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Thomas Maloney 4814 71st Avenue, Hyattsville, Maryland 20784

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 13 1995	[signature]

5

OHMH-16 Rev 1/89

95 20272

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Evelyn June King			2. DATE OF DEATH (Month, Day, Year): June 13, 1995		3. TIME OF DEATH: 6:00 PM
4. SOCIAL SECURITY NUMBER: 213-18-8358	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 73 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Feb. 15, 1922	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Frederick		9c. COUNTY OF DEATH: Frederick	
RESIDENCE OF DECEDENT						
10a. STATE: Maryland	10b. COUNTY: Frederick		10c. CITY, TOWN OR LOCATION: Frederick		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO	
10e. STREET AND NUMBER: 8708 Indian Springs Road			10f. ZIP CODE: 21702		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7	College (1-4 or 5 +):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker		16b. KIND OF BUSINESS/INDUSTRY: Home	
17. FATHER'S NAME (First, Middle, Last): Joshua KING			18. MOTHER'S NAME (First, Middle, Maiden Surname): Miriam BOONE			
19a. INFORMANT'S NAME (Type/Print): Mr. Bernard E. King			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8708 Indian Springs Road, Frederick, MD 21702			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place): Mount Olivet Cemetery, June 17, 1995	DATE	20c. LOCATION — City or Town, State: Frederick, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] M00703			22. NAME AND ADDRESS OF FACILITY: Keeney & Basford P.A. Funeral Home 106 East Church St., Frederick, MD 21701			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CALCIPHYLAXIS — 1 WEEK

DUE TO (OR AS A CONSEQUENCE OF):
b. END STAGE RENAL DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF):
c.

DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
GANGRENE OF LOWER EXTREMITIES

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD

29c. LICENSE NUMBER: D41717

29d. DATE SIGNED (Month, Day, Year): ▶ 6/14/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 56 THOMAS JOHNSON DRIVE FREDERICK, MD 21702

31. DATE FILED (Month, Day, Year): JUN 16 1995

32. REGISTRAR'S SIGNATURE: [signature]

DHMH-18 Rev 1/89

CLARADELL KAISER

95 20273

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CLARADELL KAISER			2. DATE OF DEATH (Month, Day, Year): June 16 1995	3. TIME OF DEATH: 2:25 A M
4. SOCIAL SECURITY NUMBER: 214-74-5379	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 84 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): DEC. 25, 1910	8. BIRTHPLACE (State or Foreign Country): OHIO
9a. FACILITY NAME (If not institution, give street and number): Salisbury Nursing & Rehab Center		9b. CITY, TOWN OR LOCATION OF DEATH: Salisbury, Md. 21801		9c. COUNTY OF DEATH: Wicomico
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: WICOMICO	10c. CITY, TOWN OR LOCATION: SALISBURY		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 5207 ALABAMA AVENUE, APT. 16		10f. ZIP CODE: 21801		10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY: -
17. FATHER'S NAME (First, Middle, Last): PATRICK HACKETT			18. MOTHER'S NAME (First, Middle, Maiden Surname): MARGARET ANN DEARTH	
19a. INFORMANT'S NAME (Type/Print): CATHERINE HASTINGS		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 301 BROOKVIEW DRIVE, SALISBURY, MD 21801		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): WALSTON SWITCH CEMETERY	DATE: 6/19	20c. LOCATION — City or Town, State: PARSONSBURG, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald W. Zeller		22. NAME AND ADDRESS OF FACILITY: ZELLER FUNERAL HOME, 1212 OLD OCEAN CITYRD P.O. BOX 3171, SALISBURY, MD 21802		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	abdominal mass	months
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	abdominal ascites	weeks.
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ ND

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]

29c. LICENSE NUMBER: D-29349

29d. DATE SIGNED (Month, Day, Year): 6/16/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): WILLIAM ROBINS M.D., 1104 HEALTHWAY DR., Salisbury, Md. 21801

31. DATE FILED (Month, Day, Year): JUN 2 0 1995

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 20274

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JAMES F. KNAPP		2. DATE OF DEATH (Month, Day, Year): June 15 1995	3. TIME OF DEATH: 4:50a. M
4. SOCIAL SECURITY NUMBER: 220-40-3673	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 52 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Sept. 6, 1942
8. BIRTHPLACE (State or Foreign Country): Washington,DC			
9a. FACILITY NAME (If not Institution, give street and number): Southern Maryland Hospital Center	9b. CITY, TOWN OR LOCATION OF DEATH: Clinton	9c. COUNTY OF DEATH: Prince George's	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Clinton	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 9610 Beverly Ave.	10f. ZIP CODE: 20735	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: 1972-1976	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Field Service Representative	16b. KIND OF BUSINESS/INDUSTRY: Gulf Stream Aerospace	
17. FATHER'S NAME (First, Middle, Last): Dail William Knapp		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Hester Little	
19a. INFORMANT'S NAME (Type/Print): Anne Knapp	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9610 Beverly Ave., Clinton, MD 20735		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): MD Veterans Cemetery	DATE: June 19,1995	20c. LOCATION — City or Town, State: Cheltenham, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]	22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home, INc. 6633 Old Alexander Ferry Rd. Clinton, MD 20735		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic cardiovascular disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES XX NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: XX 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D21230	29d. DATE SIGNED (Month, Day, Year): ▶ June 15, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Augusto P. Rodriguez, M.D. 5009 Rayburn Ct., Camp Springs, MD 20748		
31. DATE FILED (Month, Day, Year): JUN 20 1995	32. REGISTRAR'S SIGNATURE: [signature]	

DNMH-16 Rev 1/89

95 20275

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Maureen A. Lonergan			2. DATE OF DEATH (Month, Day, Year): June 9 1995	3. TIME OF DEATH: 9:40 PM M
4. SOCIAL SECURITY NUMBER: 041 26 7414	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 62 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Jan. 3, 1933	8. BIRTHPLACE (State or Foreign Country): Connecticut
9a. FACILITY NAME (If not institution, give street and number): 16108 Artistry Place		9b. CITY, TOWN OR LOCATION OF DEATH: Bowie		9c. COUNTY OF DEATH: Prince George's
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Bowie		10d. INSIDE CITY LIMITS? ☒ 1 YES 2 ☐ NO
10e. STREET AND NUMBER: 16108 Artistry Place		10f. ZIP CODE: 20716		10g. CITIZEN OF WHAT COUNTRY? United States
11. MARITAL STATUS: 1 ☐ Never Married ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Athletic Director	16b. KIND OF BUSINESS/INDUSTRY: Catholic School	
17. FATHER'S NAME (First, Middle, Last): Thomas McGovern		18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret Devery		
19a. INFORMANT'S NAME (Type/Print): John J. Lonergan		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 16108 Artistry Place Bowie Md. 20716		
20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland Veterans Cemetery	DATE: 6/13/95	20c. LOCATION — City or Town, State: Crownsville Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert E. Evans Pres.		22. NAME AND ADDRESS OF FACILITY: Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Breast CANCER	6 months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Harvey J. Kazan MD	29c. LICENSE NUMBER: D20352	29d. DATE SIGNED (Month, Day, Year): ▶ 6/12/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Harvey J. Kazan 8926 Woodyard Rd. Clinton MD		
31. DATE FILED (Month, Day, Year): JUN 14 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

OHMH-16 Rev 1/89

95 20276

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
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TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ADELE D. LIVESEY			2. DATE OF DEATH (Month, Day, Year): JUNE 6 1995	3. TIME OF DEATH: 5:45 PM
4. SOCIAL SECURITY NUMBER: 577-01-4466	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 94 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): AUG. 27, 1900	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): NATIONAL LUTHERAN HOME		9b. CITY, TOWN OR LOCATION OF DEATH: ROCKVILLE		9c. COUNTY OF DEATH: MONTGOMERY CO.

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: BETHESDA	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 5215- CEDAR LANE		10f. ZIP CODE: 20814	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): EMPLOYEE	16b. KIND OF BUSINESS/INDUSTRY: RETAIL SALES	
17. FATHER'S NAME (First, Middle, Last): JOSEPH S. DUNN		18. MOTHER'S NAME (First, Middle, Maiden Surname): ELIZABETH STEINICK	
19a. INFORMANT'S NAME (Type/Print): CHAPLAIN SIMONSON		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9701- VEIRS DR., ROCKVILLE, MD. 20850	
20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): DRUID RIDGE CEMETERY	DATE: 6/12	20c. LOCATION — City or Town, State: BALTIMORE, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ W.M. Thorn		22. NAME AND ADDRESS OF FACILITY: HYSONG CO., INC. 1300- N STREET, NW, WASH., DC	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardio Respiratory Arrest	Immed.
DUE TO (OR AS A CONSEQUENCE OF): b.	Severe anemia	11 mos
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	Chronic gastritis	4 mos
d.	Cerebrosclerotic cardiovascular disease	4 mos

PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: ☒ 1 Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Charles W. Karesh	29c. LICENSE NUMBER: D21726	29d. DATE SIGNED (Month, Day, Year): June 6/7/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. CHARLES W. KARESH- 9701- VEIRS DRIVE, ROCKVILLE, MD. 20850		
31. DATE FILED (Month, Day, Year): JUN 12 1995	32. REGISTRAR'S SIGNATURE: Jane Hamilton-Randall	

DHMH-16 Rev 1/89

Amended # 16b,PG,GC,6/12/95

95 20277

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): George P. Loop			2. DATE OF DEATH (Month, Day, Year): June 11, 1995	3. TIME OF DEATH: 10A M
4. SOCIAL SECURITY NUMBER: 215-70-8160	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 39 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 5/25/56	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 2207 Iverson St.		9b. CITY, TOWN OR LOCATION OF DEATH: Temple Hills		9c. COUNTY OF DEATH: Prince George's

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Temple Hills	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2207 Iverson St.		10f. ZIP CODE: 20748	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: 1973-1974	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Bartender	16b. KIND OF BUSINESS/INDUSTRY: Restaurant ~~Restaurent~~	
17. FATHER'S NAME (First, Middle, Last): Stephen Loop		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary M. Refowich	
19a. INFORMANT'S NAME (Type/Print): Janet L. Loop		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as item 10	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place): Metropolitan Crematory DATE: 6/12/95	20c. LOCATION — City or Town, State: Alexandria, Va.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: George P. Kalas		22. NAME AND ADDRESS OF FACILITY: George P. Kalas Funeral Home, 6160 Oxon Hill Rd. Oxon Hill, Md. 20745	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Lymphoma DUE TO (OR AS A CONSEQUENCE OF):	year
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hepatic cirrhosis, jaundice, ascitis, hemorrhoids

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [X] NO [ ] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO — 28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Augusto P. Rodriguez MD	29c. LICENSE NUMBER: D 21230	29d. DATE SIGNED (Month, Day, Year): June 11, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Augusto P. Rodriguez MD, 5009 Rayburn Ct. Cheverly MD 20748		
31. DATE FILED (Month, Day, Year): JUN 12 1995	32a. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

(5)

DHMH-16 Rev 1/89

95 20278

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DANIEL HENRY LANDOLT		2. DATE OF DEATH (Month, Day, Year): JUNE 6 1995	3. TIME OF DEATH: 4:00 AM
4. SOCIAL SECURITY NUMBER: 213-40-6045	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 53 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Oct. 30, 1941
8. BIRTHPLACE (State or Foreign Country): Washington, DC			
9a. FACILITY NAME (If not institution, give street and number): 41 B Street, #24	9b. CITY, TOWN OR LOCATION OF DEATH: Laurel	9c. COUNTY OF DEATH: PRINCE GEORGE'S	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Laurel	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 41 B Street, #24		10f. ZIP CODE: 20707	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Construction Manager	16b. KIND OF BUSINESS/INDUSTRY: Construction Industry	
17. FATHER'S NAME (First, Middle, Last): Herbert L. Landolt		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary A. Rolfes	
19a. INFORMANT'S NAME (Type/Print): Robert Landolt	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10223 Sunway Terrace, Ellicott City, Maryland 21042		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Gate of Heaven Cemetery DATE 6/17/95	20c. LOCATION — City or Town, State: Silver Spring, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: W.B. Gasch	22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE	UNK
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

manic-depressive psychosis, obesity, alcoholism

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☒ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: J.M. Berger MD	29c. LICENSE NUMBER: D25925	29d. DATE SIGNED (Month, Day, Year): June 12, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. BERGER MD #205, 7720 Wisconsin Ave, Bethesda, Md. 20814

31. DATE FILED (Month, Day, Year): JUN 13 1995	32. REGISTRAR'S SIGNATURE: Julia Theodora Randall

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DHMH-18 Rev 1/89

95 20279

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
SEAN	D	LYNN	JUNE 4 1995	10:45A M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
059-70-4563	1 [X] M 2 [ ] F	24 YRS.			Sep.23,1970	North Carolina

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Southern Maryland Hospital	Clinton	Prince Georg'es

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MD	Prince George's	Temple Hills	1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
6307 George Washington Drive	20748	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] YES 2 [X] NO	1 [ ] YES 2 [X] NO Specify:	Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
	1yr	Security Guard	Private

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Michael J Lynn, Sr.	Diana Taylor

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Michael Lynn, Sr.	6307 George Washington Dr. Temple Hills, Md. 20748

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
[X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Harmony Memorial Park	Jun10	Landover, MD.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Kimberly C Bruce-Tonic	J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, MD.20785

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pulmonary Embolus Respiratory Arrest Recall	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Pulmonary Embolus, massive	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Obesity - immobility	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [✓] YES 2 [ ] NO	1 [✓] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [✓] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	28. PLACE OF DEATH (Check only one)	
1 [ ] YES 2 [ ] NO	HOSPITAL: 1 [ ] Inpatient 2 [✓] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	26a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY	26c. INJURY AT WORK?	26d. DESCRIBE HOW INJURY OCCURED
1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] YES 2 [ ] ND	

26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Rginders	D19188	▶ 6/5/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
REKHA GINDE, MD, Southern Md Hospital, Lab, Clinton, MD

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 13 1995	Julia Davidson Rader

DHMH-16 Rev 1/89

95 20280

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MILTON EDWARD LAMB JR.			2. DATE OF DEATH (Month, Day, Year): JUNE 10, 1995	3. TIME OF DEATH: 21:13 M
4. SOCIAL SECURITY NUMBER: 228-20-5040	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 73 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): JANUARY 7, 1922	8. BIRTHPLACE (State or Foreign Country): CHOWAN NORTH CAROLINA
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH: NONE

RESIDENCE OF DECEDENT

10a. STATE: North Carolina	10b. COUNTY: Chowan	10c. CITY, TOWN OR LOCATION: Edenton	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 304 Indian Trail Road		10f. ZIP CODE: 27932	10g. CITIZEN OF WHAT COUNTRY? United States of America

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cutter	16b. KIND OF BUSINESS/INDUSTRY: Leather	
17. FATHER'S NAME (First, Middle, Last): Milton Edward Lamb		18. MOTHER'S NAME (First, Middle, Maiden Surname): Alice Martin	
19a. INFORMANT'S NAME (Type/Print): Verta M. Lamb	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 304 Indian Trail Road, Edenton, North Carolina 27932		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Cemetery Saint John Baptist Church	DATE	20c. LOCATION — City or Town, State: Edenton, North Carolina
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Howard A Causan #M00690	22. NAME AND ADDRESS OF FACILITY: Blair Funeral Service 141 East Carteret Street, Edenton, NC 27932		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Aspiration pneumonia	3 days
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Large stroke — DUE TO (OR AS A CONSEQUENCE OF):	20 days
	c. — DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [X]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD	29c. LICENSE NUMBER: M5109	29d. DATE SIGNED (Month, Day, Year): ▶ 6/10/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Xue Ming, 600 N Wolfe St. Baltimore MD 21287		
31. DATE FILED (Month, Day, Year): JUN 15 1995	32. REGISTRAR'S SIGNATURE: [illegible] Randall	

DHMH-16 Rev 1/89

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95 20281

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Blanche Regina Leather					2. DATE OF DEATH (Month, Day, Year): June 20, 1995	3. TIME OF DEATH: 1:35 P M
4. SOCIAL SECURITY NUMBER: 213-16-0740	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 74 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Jul 13, 1920	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Long View Nursing Home			9b. CITY, TOWN OR LOCATION OF DEATH: Manchester			9c. COUNTY OF DEATH: Carroll
RESIDENCE OF DECEDENT						
10a. STATE: Maryland	10b. COUNTY: Carroll		10c. CITY, TOWN OR LOCATION: Hampstead			10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 4001 West Mott Avenue			10f. ZIP CODE: 21074			10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 / College (1-4 or 5+)			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Press Operator			16b. KIND OF BUSINESS/INDUSTRY: Jos. A. Banks
17. FATHER'S NAME (First, Middle, Last): Alver Ruby			18. MOTHER'S NAME (First, Middle, Maiden Surname): Elsie Hilker			
19a. INFORMANT'S NAME (Type/Print): Janet Sams			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1325 Brilhart Dr, Hampstead, MD 21074			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place): Hampstead Cemetery DATE: 6/23			20c. LOCATION — City or Town, State: Hampstead, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Steven W. Eline			22. NAME AND ADDRESS OF FACILITY: Eline Funeral Home 934 S Main St, Hampstead, MD 21074			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Breast Cancer	2 years
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's Dementia

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD | 29c. LICENSE NUMBER: D53165 | 29d. DATE SIGNED (Month, Day, Year): ▶ 6/20/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Steven Stotter MD 2111 Hanover Pike Hampstead MD 21074

31. DATE FILED (Month, Day, Year): JUN 21 1995 | 32. REGISTRAR: Julia Woodward-Randall

OHMH-16 Rev 1/89

95 20282

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CLAUDIOUS S. LEE				2. DATE OF DEATH (Month, Day, Year): JUN 14 95	3. TIME OF DEATH: 2:15 AM
4. SOCIAL SECURITY NUMBER: 220-14-9812	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 86 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): May 16, 1909	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): CITIZENS NURSING HOME			9b. CITY, TOWN OR LOCATION OF DEATH: HAVRE DE GRACE		9c. COUNTY OF DEATH: HARFORD

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Havre de Grace	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 510 Robin Hood Road		10f. ZIP CODE: 21078	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Farmer	16b. KIND OF BUSINESS/INDUSTRY: Self Employed	
17. FATHER'S NAME (First, Middle, Last): William D. Lee		18. MOTHER'S NAME (First, Middle, Maiden Surname): Katherine Silver	
19a. INFORMANT'S NAME (Type/Print): JoAnn E. Lynn		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7 West Aztec Street, Aberdeen, MD 21001	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Rock Run Cemetery	DATE: 6/17	20c. LOCATION — City or Town, State: Havre de Grace, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Kelly A. Younker		22. NAME AND ADDRESS OF FACILITY: Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. terminal chronic obstructive lung disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Coronary artery disease, hypertension, Dementia,

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [X] NO [ ] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Henry Tim Kim	29c. LICENSE NUMBER: D37364	29d. DATE SIGNED (Month, Day, Year): ▶ June 15, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 219 W. Bel Air Avenue, Aberdeen, Maryland 21001		
31. DATE FILED (Month, Day, Year): JUN 16 1995	REGISTRAR'S SIGNATURE: Julia Anderson-Randall	

DHMH-16 Rev 1/89

95 20283

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mabel Irene LINGER				2. DATE OF DEATH (Month, Day, Year): June 16, 1995	3. TIME OF DEATH: 5:02 AM M
4. SOCIAL SECURITY NUMBER: 235-18-1324	5. SEX: 1 ☐ M 2 XX F	8. AGE (In yrs. last birthday): 85 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): March 3, 1910	6. BIRTHPLACE (State or Foreign Country): WestVirginia
9a. FACILITY NAME (If not institution, give street and number): Citizens Nursing Home			9b. CITY, TOWN OR LOCATION OF DEATH: Frederick		9c. COUNTY OF DEATH: Frederick
RESIDENCE OF DECEDENT					
10a. STATE: Maryland	10b. COUNTY: Frederick		10c. CITY, TOWN OR LOCATION: Frederick		10d. INSIDE CITY LIMITS? XX 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 300 East Third Street			10f. ZIP CODE: 21701		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Waitress		16b. KIND OF BUSINESS/INDUSTRY: Food Service
17. FATHER'S NAME (First, Middle, Last): John LINGER			18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Effie CARTER		
19a. INFORMANT'S NAME (Type/Print): Stephen E. Linger			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 226 Carroll Parkway, Frederick, Maryland 21701		
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Mount Olivet Cemetery June 19,	DATE: 1995	20c. LOCATION — City or Town, State: Frederick, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Richard E. Graf M00255			22. NAME AND ADDRESS OF FACILITY: Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pneumonia	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. cerebral vascular disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: seizure disorder

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	D22101	▶ 6/16/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 1475 Jung Ave Frederick Md 21701

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 19 1995	Julia Davidson Randall

DHMH-16 Rev 1/89

95 20284

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Charles Norris Lowe		2. DATE OF DEATH (Month, Day, Year): June 15, 1995	3. TIME OF DEATH: 1:00 PM
4. SOCIAL SECURITY NUMBER: 579-09-2908	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 84 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): March 4, 191[illegible]
8. BIRTHPLACE (State or Foreign Country): Maryland			
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Frederick	9c. COUNTY OF DEATH: Frederick	
RESIDENCE OF DECEDENT			
10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Frederick	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: 1415 Key Parkway	10f. ZIP CODE: 21702	10g. CITIZEN OF WHAT COUNTRY?: United States	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECEHDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Draftsman	16b. KIND OF BUSINESS/IHDUSTRY: Dept. of Commerce	
17. FATHER'S NAME (First, Middle, Last): Harry Lowe	18. MOTHER'S NAME (First, Middle, Maiden Surname): Flora H. Marshall		
19a. IHFORMANT'S HAME (Type/Print): Margaret D. Lowe	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1415 Key Parkway Frederick, MD 21702		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Resthaven Memorial Gardens	DATE: 6/17/95	20c. LOCATION — City or Town, State: Frederick, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. HAME AND ADDRESS OF FACILITY: Stauffer Funeral Homes, P.A 1621 Opossumtown Pike Frederick, MD 21702		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arreat, shock, or heart feilure. List only one cause on each line.

Approximate interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Chronic Renal Failure — DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST

b. Arteriosclerosis glomerulosclerosis. — DUE TO (OR AS A CONSEQUENCE OF):

c. — DUE TO (OR AS A CONSEQUENCE OF):

d.

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.: COPD, ASHD, PVD a Smoker hist.

24a. WAS AH AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [X] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMIHER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MAHHER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF IHJURY (Month, Day, Year) / 28b. TIME OF IHJURY / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW IHJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYIHG PHYSICIAH: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: W Riddick MD	29c. LICEHSE HUMBER: D-12467	29d. DATE SIGHED (Month, Day, Year): 6/16/95

30. HAME AHD ADDRESS OF PERSOH WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Willis J. Riddick, M.D. 516 Trail Ave. Frederick, Maryland 21701

31. DATE FILED (Month, Day, Year): JUN 19 1995	32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

95 20285

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MADELINE NEVA LEWIS			2. DATE OF DEATH (Month, Day, Year): June 13, 1995	3. TIME OF DEATH: 1:00 A M
4. SOCIAL SECURITY NUMBER: 214-10-3915	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 82 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 19, 1913	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 37 Blue Ridge Avenue		9b. CITY, TOWN OR LOCATION OF DEATH: Thurmont		9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Thurmont	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 37 Blue Ridge Avenue		10f. ZIP CODE: 21788	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: None	
17. FATHER'S NAME (First, Middle, Last): Charles H. Stitley		18. MOTHER'S NAME (First, Middle, Maiden Surname): Esther F. Carty	
19a. INFORMANT'S NAME (Type/Print): Darrel Jacen Lewis	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 37 Blue Ridge Avenue Thurmont, Maryland 21788		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Blue Ridge Cemetery	DATE: 6/16	20c. LOCATION — City or Town, State: Thurmont, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert E. Dailey Jr.	22. NAME AND ADDRESS OF FACILITY: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN STREET THURMONT, MD 21788		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Head and Neck Cancer	1 year
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: COPD

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☑ Residence 8 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Allen J Gilson MD	29c. LICENSE NUMBER: D26516	29d. DATE SIGNED (Month, Day, Year): ▶ June 16, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Allen J. Gilson MD 1475 Taney Avenue Frederick, MD 21701		
31. DATE FILED (Month, Day, Year): JUN 16 1995	32. REGISTRAR'S SIGNATURE: Julia Shuster Radcliffe	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 20286

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EDWARD Earl LEBEAU			2. DATE OF DEATH: MONTH JUNE DAY 12 YEAR 95	3. TIME OF DEATH: 553 A M
4. SOCIAL SECURITY NUMBER: 577-38-3275	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): June 10, 1921	8. BIRTHPLACE (State or Foreign Country): Michigan
9a. FACILITY NAME (If not institution, give street and number): Southern Maryland Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Clinton		9c. COUNTY OF DEATH: Prince George's

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George	10c. CITY, TOWN OR LOCATION: Camp Springs	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 5216 Lorraine Drive		10f. ZIP CODE: 20748	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: 1939-1945 W.W. II	13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5 +): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Engineering Technician	16b. KIND OF BUSINESS/INDUSTRY: Naval Research Lab	
17. FATHER'S NAME (First, Middle, Last): Frank LeBeau		18. MOTHER'S NAME (First, Middle, Maiden Surname):	
19a. INFORMANT'S NAME (Type/Print): Alice Emma LeBeau		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5216 Lorraine Drive, Camp Springs, Md 20748	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland Veterans Cemetery DATE: June 15, 1995	20c. LOCATION — City or Town, State: Cheltenham, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home, Inc 6633 Old Alexander Ferry Road, Clinton, Md 20735	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	MASSIVE UPPER INTESTINAL HEMORRAGE	6hr
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	METASTATIC CARCINOMA LUNG BONE ADRENAL GLANDS	8WK
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: R.A.M.C Connaughty MD	29c. LICENSE NUMBER: D07287	29d. DATE SIGNED (Month, Day, Year): ▶ JUNE 12, 95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): R.A.M.C CONNAUGHTY MD; 11418 LIVINGSTON Rd. Fort Washington MD 20744		
31. DATE FILED (Month, Day, Year): JUN 20 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall	

OHMH-16 Rev 1/89

95-3392-033
CIP

ITEMS: 23 PART I, II, 27,28a-f, PER MEO FILM G-725 7/21/95 t.t

95 20287

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DIZZY DEAN McGHEE					2. DATE OF DEATH (Month, Day, Year): JUNE 9, 1995	3. TIME OF DEATH: 3:20 P M
4. SOCIAL SECURITY NUMBER: 242-60-6798	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 54 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): August 25, 1940	8. BIRTHPLACE (State or Foreign Country): North Carolina
9a. FACILITY NAME (If not institution, give street and number): 7300 BLOCK BARLOWE ROAD			9b. CITY, TOWN OR LOCATION OF DEATH: LANDOVER		9c. COUNTY OF DEATH: PRINCE GEORGES	
RESIDENCE OF DECEDENT						
10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Landover			10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO	
10e. STREET AND NUMBER: 1927 Ray Leonard Road		10f. ZIP CODE: 20785			10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6th; College (1-4 or 5 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Supervisor	16b. KIND OF BUSINESS/INDUSTRY: Private				
17. FATHER'S NAME (First, Middle, Last): Walter McGhee, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Fannie Garrett				
19a. INFORMANT'S NAME (Type/Print): Bernice McGhee	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1927 Ray Leonard Road, Landover, Md 20785					
20a. METHOD OF DISPOSITION: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): St. James Baptist Church Cem.	DATE: 6/15/95	20c. LOCATION — City or Town, State: Somora, N.C.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John T. Stewart III	22. NAME AND ADDRESS OF FACILITY: Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019					

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ACUTE ETHANOL INTOXICATION	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.: CIRRHOSIS OF THE LIVER

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [X] Other (Specify) VACANT LOT

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [X] Pending Investigation 6 [X] Could not be determined

28a. DATE OF INJURY (Month, Day, Year): FOUND 6-9-95
28b. TIME OF INJURY: FOUND AT 2:00 P M
28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO
28d. DESCRIBE HOW INJURY OCCURED: UNKNOWN
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): FOUND IN FIELD
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 300 BLK. BURLOWE ROAD LANDOVER, MARYLAND

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Dennis J. Chute M.D.
29c. LICENSE NUMBER: O.C.M.E.
29d. DATE SIGNED (Month, Day, Year): ▶ JUNE 13, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DENNIS J. CHUTE M.D. 111 Penn Street, Baltimore, Maryland 21201

31. DATE FILED (Month, Day, Year): JUN 16 1995
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

95-3084-033
B.K.S
95-135

Amended # 10e, P.G., GC, 6/14/95

95 20288

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RALPH McLEAN			2. DATE OF DEATH (Month, Day, Year): MAY 29, 1995	3. TIME OF DEATH: 0500 A M
4. SOCIAL SECURITY NUMBER: 579-96-1116	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 29 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Feb. 14, 1966	8. BIRTHPLACE (State or Foreign Country): Wash, DC
9a. FACILITY NAME (If not institution, give street and number): 6300 GREENBELT DRIVE			9b. CITY, TOWN OR LOCATION OF DEATH: GREENBELT		9c. COUNTY OF DEATH: PRINCE GEORGES

RESIDENCE OF DECEDENT

10a. STATE: Md	10b. COUNTY: PG	10c. CITY, TOWN OR LOCATION: Landover	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2328 ~~Virginf~~ Virginia Ave, # 202		10f. ZIP CODE: 20785	10g. CITIZEN OF WHAT COUNTRY?: U.S./

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Carrier	16b. KIND OF BUSINESS/INDUSTRY: Unknown	
17. FATHER'S NAME (First, Middle, Last): Ralph Moody		18. MOTHER'S NAME (First, Middle, Maiden Surname): Shirley McLean	
19a. INFORMANT'S NAME (Type/Print): Marquiter McLean		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 617 P Street, NW, Wash. DC 20001	

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Glenwood Cemetery	DATE: 6-5-95	20c. LOCATION — City or Town, State: Washington, DC
21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FACILITY: Austin Royster Funeral Home 3605 14th Street, NW, Wash. DC	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Contact gunshot wound of head		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Multiple gunshot wounds

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? [XX] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence [XX] Other (Specify): MALL	

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): MAY 29 1995	28b. TIME OF INJURY: 0030 M	28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO	28d. DESCRIBE HOW INJURY OCCURED: SHOT SELF WHILE BEING PURSUED BY POLICE
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): STREET			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 6300 Blk Greenbelt Pl

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [XX] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: A. DIXON	29c. LICENSE NUMBER: O.C.M.E	29d. DATE SIGNED (Month, Day, Year): ▶ MAY 29,1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A. DIXON 111 PENN STREET BALTIMORE, MARYLAND 21201		
31. DATE FILED (Month, Day, Year): JUN 14 1995	32. REGISTRAR'S SIGNATURE: Julia A. Anderson-Randall	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 20289

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ELEANOR MAE MATTHEWS				2. DATE OF DEATH (Month, Day, Year): June 6, 1995	3. TIME OF DEATH: 3:00P M
4. SOCIAL SECURITY NUMBER: 212-54-5583	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 53 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): June 25,1941	8. BIRTHPLACE (State or Foreign Country): Laurel, MD
9a. FACILITY NAME (If not institution, give street and number): 9936 Naylor Avenue			9b. CITY, TOWN OR LOCATION OF DEATH: Laurel		9c. COUNTY OF DEATH: Prince Georges
RESIDENCE OF DECEDENT					
10a. STATE: MD	10b. COUNTY: Prince Georges		10c. CITY, TOWN OR LOCATION: Laurel		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 9936 Naylor Avenue			10f. ZIP CODE: 20723		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Domestic		16b. KIND OF BUSINESS/INDUSTRY: Milestone Manor
17. FATHER'S NAME (First, Middle, Last): Charles Cole			18. MOTHER'S NAME (First, Middle, Maiden Surname): Corinthia Haskins		
19a. INFORMANT'S NAME (Type/Print): Debra Johnson-Robinson			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15015 Kalmia Drive, Laurel, MD 20707		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland Nat'l. Cemetery DATE: 6/13		20c. LOCATION — City or Town, State: Laurel, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ J.P. Marshall			22. NAME AND ADDRESS OF FACILITY: Marshall's Funeral Home, Inc. 4308 Suitland Rd. Suitland, MD 20746		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory Failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Aspiration Pneumonia	1 wk
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Lung Cancer Stage IV	3 yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: chronic anemia, anorexic

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

28. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
26a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Jon Minford	D30573	▶ 6-9-95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jon Minford- 11065 Little Patuxent Parkway, Columbia, MD 21044

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 14 1995	Julia Davidson Randall

(5)

DHMH-16 Rev 1/89

Amended # 7,P.G.GC,6/13/95

95 20290

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LAURA MOXLEY			2. DATE OF DEATH (Month, Day, Year): JUNE 10 95	3. TIME OF DEATH: 6:30 A M
4. SOCIAL SECURITY NUMBER: 268-26-4301	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 88 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Oct. 14, 1906	8. BIRTHPLACE (State or Foreign Country): Alabama
9a. FACILITY NAME (If not institution, give street and number): Prince George's Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly		9c. COUNTY OF DEATH: Prince George's
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Upper Marlboro		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 4311 Canyon View Drive		10f. ZIP CODE: 20772		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Domestic		16b. KIND OF BUSINESS/INDUSTRY: Private
17. FATHER'S NAME (First, Middle, Last): Phillip Driver		18. MOTHER'S NAME (First, Middle, Maiden Surname): Martha		
19a. INFORMANT'S NAME (Type/Print): Sammie Whitehead		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4311 Canyon View Dr. Upper Marlboro,MD 20772		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill DATE: jun 17		20c. LOCATION — City or Town, State: Suitland,MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jeanara L. Braxton		22. NAME AND ADDRESS OF FACILITY: J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, Md. 20785		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	AZOTEMIA	6/8/95
DUE TO (OR AS A CONSEQUENCE OF): b.	Acute Bowel obstruction	6/8/95
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	Acute Respiratory Failure	6/8/95
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Rakesh Arora	D20108	▶ 6/10/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RAKESH ARORA 14300 GALLANT FOX LANE 222 BOWIE MD

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 13 1995	John Wesley Parker

DHMH-16 Rev 1/89

(1)

95 20291

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOSEPH MORGAN
2. DATE OF DEATH (Month, Day, Year): 6 6 95
3. TIME OF DEATH: 11 PM
4. SOCIAL SECURITY NUMBER: 577-12-7044
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 81 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 12-1-1913
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): GNCC
9b. CITY, TOWN OR LOCATION OF DEATH: BETHESDA MD
9c. COUNTY OF DEATH: montgomery

RESIDENCE OF DECEDENT

10a. STATE: DC
10b. COUNTY: None
10c. CITY, TOWN OR LOCATION: Washington, D. C.
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 4509 Alabama Avenue, S. E.;Wash.,DC
10f. ZIP CODE: 20020
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6th — College (1-4 or 5 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Custodian
16b. KIND OF BUSINESS/INDUSTRY: Government
17. FATHER'S NAME (First, Middle, Last): James O. Morgan
18. MOTHER'S NAME (First, Middle, Maiden Surname): Clara E. Clayton
19a. INFORMANT'S NAME (Type/Print): Geneieve Morgan
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4509 Alabama Ave., SE; Washington,DC 20020
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Quantico Nat. Cemetery — DATE: Jun 13,1995
20c. LOCATION — City or Town, State: Quantico, VA.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ralph Williams 750
22. NAME AND ADDRESS OF FACILITY: Ralph Williams Funeral Service 517 11th Street, SE; Wash., DC

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter tha mode of dying, such as cerdiec or reepiratory errest, ehock, or heert failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	CVA	1990
DUE TO (OR AS A CONSEQUENCE OF):	HBP	1990
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.		
DUE TO (OR AS A CONSEQUENCE OF):	ASVD	1990
c.		
DUE TO (OR AS A CONSEQUENCE OF):	DM2D	1990
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Senile Dementia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year): N/A
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: G B Patrick MD
29c. LICENSE NUMBER: D17729
29d. DATE SIGNED (Month, Day, Year): 6/7/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): G B Patrick MD 9321 Colesville Rd SS, Md 20910
31. DATE FILED (Month, Day, Year): JUN 15 1995
32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DHMH-16 Rev 1/89

(2)

th

James O. Morgan

Genieve Morgan

X

Custodian

Clara E. Clayton

Government

4509 Alabama Ave., SE; Washington,DC 20020

Quantico Nat. Cemetery,Jun13,1995 Quantico, VA.

95 20292

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ann Noel Murdock
2. DATE OF DEATH (Month, Day, Year): June 17, 1995
3. TIME OF DEATH: 04:40 A M
4. SOCIAL SECURITY NUMBER: 218-80-9218
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 80 YRS. (If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.)
7. DATE OF BIRTH (Month, Day, Year): Dec 1, 1914
8. BIRTHPLACE (State or Foreign Country): New York
9a. FACILITY NAME (If not institution, give street and number): Calvert Memorial Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Prince Frederick
9c. COUNTY OF DEATH: Calvert

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Calvert
10c. CITY, TOWN OR LOCATION: North Beach
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 4034 8th Street
10f. ZIP CODE: 20714
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): housewife
16b. KIND OF BUSINESS/INDUSTRY: own home
17. FATHER'S NAME (First, Middle, Last): Edward Hickey
18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie Noel
19a. INFORMANT'S NAME (Type/Print): Harry E. Murdock
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as # 10 above
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery — DATE: 6-20-95
20c. LOCATION — City or Town, State: Brentwood, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ William R. Gross
22. NAME AND ADDRESS OF FACILITY: Rausch Funeral Home, P.A. Owings, MD

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Carcinoma Lung.	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Congestive heart Failure

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Zahir Yousaf M.D.
29c. LICENSE NUMBER: D 27189
29d. DATE SIGNED (Month, Day, Year): ▶ 6/17/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Zahir Yousaf M.D. Prince Frederick, Md. 20678

31. DATE FILED (Month, Day, Year): JUN 20 1995
32. REGISTRAR'S SIGNATURE: Julie Strickler-Randall

DHMH-16 Rev 1/89

95-3428-009
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95 20293

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ALEXANDER MACKALL					2. DATE OF DEATH (Month, Day, Year): JUNE 11 1995	3. TIME OF DEATH: 9:30 PM
4. SOCIAL SECURITY NUMBER: 213-96-5115	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 14 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Oct. 8, 1980	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 12940 ROUSBY HALL ROAD			9b. CITY, TOWN OR LOCATION OF DEATH: LUSBY		9c. COUNTY OF DEATH: CALVERT	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Calvert	10c. CITY, TOWN OR LOCATION: Lusby	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO	
10e. STREET AND NUMBER: 12940 Rousby Hall Road		10f. ZIP CODE: 20657	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Student	16b. KIND OF BUSINESS/INDUSTRY: School		
17. FATHER'S NAME (First, Middle, Last): McKinley Mackall		18. MOTHER'S NAME (First, Middle, Maiden Surname): Wanda Buck		
19a. INFORMANT'S NAME (Type/Print): McKinley Mackall		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 431 Brandywine St. S.E. Washington, D.C. 20032		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Eastern UM Chr. Cem.	DATE: 6/17/95	20c. LOCATION — City or Town, State: Lusby, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Spencer E. Sewell		22. NAME AND ADDRESS OF FACILITY: Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. GUNSHOT WOUNDS OF HEAD AND CHEST	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 6/11/95	28b. TIME OF INJURY: 8:30 PM	28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO
	28d. DESCRIBE HOW INJURY OCCURED: SUBJECT SHOT		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): HOME	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 12940 ROUSBY HALL ROAD	

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: O.C.M.E.	29d. DATE SIGNED (Month, Day, Year): JUNE 12,1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DAVID R FOWLER 111 Penn Street, Baltimore, Maryland 21201		
31. DATE FILED (Month, Day, Year): JUN 16 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

2

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): SHAKEYA MACKALL				2. DATE OF DEATH (Month, Day, Year): JUNE 11 1995	3. TIME OF DEATH: 9:30 PM
4. SOCIAL SECURITY NUMBER: 214-02-0059	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 12 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Oct. 23, 1982	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 12940 ROUSBY HALL ROAD				9b. CITY, TOWN OR LOCATION OF DEATH: LUSBY	9c. COUNTY OF DEATH: CALVERT
RESIDENCE OF DECEDENT					
10a. STATE: Maryland	10b. COUNTY: Calvert		10c. CITY, TOWN OR LOCATION: Lusby		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 12940 Rousby Hall Road			10f. ZIP CODE: 20657		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7	College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Student		16b. KIND OF BUSINESS/INDUSTRY: School
17. FATHER'S NAME (First, Middle, Last): McKinley Mackall				18. MOTHER'S NAME (First, Middle, Maiden Surname): Wanda Buck	
19a. INFORMANT'S NAME (Type/Print): McKinley Mackall			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 431 Brandywine St. S.E. Washington, D.C. 20032		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Eastern UM Chr. Cem. DATE: 6/17/95		20c. LOCATION — City or Town, State: Lusby, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Spencer E. Sewell			22. NAME AND ADDRESS OF FACILITY: Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. GUNSHOT WOUNDS TO HEAD AND CHEST	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☒ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
6/11/95	8:30 PM	1 ☐ YES 2 ☒ NO	SUBJECT SHOT

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
HOME	12940 ROUSBY HALL ROAD

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
	O.C.M.E.	▶ JUNE 12, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DAVID R FOWLER 111 Penn Street, Baltimore, Maryland 21201

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 16 1995	Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2

12

95 20295

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EILEEN MARIE MARKOWSKI			2. DATE OF DEATH (Month, Day, Year): June 18, 1995	3. TIME OF DEATH: 2:55 A M
4. SOCIAL SECURITY NUMBER: 218-32-0102	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 58 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): July 15, 1936	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 4022 E. Baker Ave.		9b. CITY, TOWN OR LOCATION OF DEATH: Abingdon		9c. COUNTY OF DEATH: Harford
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Abingdon		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 4022 E. Baker Ave.		10f. ZIP CODE: 21009		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Office Manager		16b. KIND OF BUSINESS/INDUSTRY: US Government
17. FATHER'S NAME (First, Middle, Last): Louis Charles Clarke			18. MOTHER'S NAME (First, Middle, Maiden Surname): Lillian Amelia Fisher	
19a. INFORMANT'S NAME (Type/Print): Henry T. Markowski		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4022 E. Baker Ave., Abingdon, Md. 21009		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Highview Memorial Gardens DATE: 6-21-95		20c. LOCATION — City or Town, State: Fallston, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Howard K. McComas		22. NAME AND ADDRESS OF FACILITY: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Md. 21009		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. METASTATIC PANCREATIC CANCER	8 MONTHS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: HEPATIC ENCEPHALOPATHY

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D31775	29d. DATE SIGNED (Month, Day, Year): JUNE 19 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOHN P EDWARDS MD 212 BELAIR ROAD FALLSTON, MARYLAND 21047		
31. DATE FILED (Month, Day, Year): JUN 20 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

95 20296

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): George Edward Myers			2. DATE OF DEATH (Month, Day, Year): June 20 1995	3. TIME OF DEATH: 4:30 AM
4. SOCIAL SECURITY NUMBER: 220-03-0999	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 2 1921	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 7 Marbeth Hill		9b. CITY, TOWN OR LOCATION OF DEATH: Westminster		9c. COUNTY OF DEATH: Carroll

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Carroll	10c. CITY, TOWN OR LOCATION: Westminster	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 7 Marbeth Hill		10f. ZIP CODE: 21157	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12):	College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): executive/president	16b. KIND OF BUSINESS/INDUSTRY: meat

17. FATHER'S NAME (First, Middle, Last): Oliver Myers	18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Logue	
19a. INFORMANT'S NAME (Type/Print): Lorraine H. Myers	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7 Marbeth Hill, Westminster, MD 21157	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Carroll Cremations Inc. DATE: 6/21/95	20c. LOCATION — City or Town, State: Hampstead, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Katherine Pritts - Sucigar	22. NAME AND ADDRESS OF FACILITY: Pritts Funeral Home & Chapel 412 Washington Rd., Westminster, MD	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Myocardial Infarction	
	DUE TO (OR AS A CONSEQUENCE OF): ASVD	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF): Prev hx CHF	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF): d. Hvessel Coronary bypass Sx	1984

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Left Ventricular Aneurysm

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD	29c. LICENSE NUMBER: D64278	29d. DATE SIGNED (Month, Day, Year): ▶ 6-20-95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		
31. DATE FILED (Month, Day, Year): JUN 21 1995	32. REGISTRAR'S SIGNATURE: Julia Dawson Randall	

DHMH-16 Rev 1/89

95 20297

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Thomas Leon Massey			2. DATE OF DEATH (Month, Day, Year): 6 / 11 / 95	3. TIME OF DEATH: 4:00 PM
4. SOCIAL SECURITY NUMBER: 216-54-9956	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 44 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 3/31/51	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): 11644 Sinepuxent RD		9b. CITY, TOWN OR LOCATION OF DEATH: Berlin		9c. COUNTY OF DEATH: Worcester

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Worcester	10c. CITY, TOWN OR LOCATION: Berlin	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 11644 Sinepuxent RD		10f. ZIP CODE: 21811	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: Vietnam	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Electrician	16b. KIND OF BUSINESS/INDUSTRY: Electrical	
17. FATHER'S NAME (First, Middle, Last): Isaac Leon Massey		18. MOTHER'S NAME (First, Middle, Maiden Surname): Jeanette Bowen	
19a. INFORMANT'S NAME (Type/Print): Leon and Jeanette Massey	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12401 Meadow Dr. Berlin, MD 21811		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Sunset Memorial Park DATE: 6/14/95	20c. LOCATION — City or Town, State: Berlin, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: W. Bill Burbage	22. NAME AND ADDRESS OF FACILITY: Burbage Funeral Home 108 Williams St. Berlin, MD 21811		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CORONARY ARTERY DISEASE	FEW HOURS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Dorothy C. Holzworth, M.D.	29c. LICENSE NUMBER: D06241	29d. DATE SIGNED (Month, Day, Year): 6-14-95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DOROTHY C. HOLZWORTH 208 SNOW ST. SNOW HILL, MD. 21863

31. DATE FILED (Month, Day, Year): JUN 14 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 20298

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Robert LEE MASON SR.
2. DATE OF DEATH (Month, Day, Year): JUNE 15 95
3. TIME OF DEATH: 1-00 P M
4. SOCIAL SECURITY NUMBER: 217-03-8230
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 80 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 12/4/1914
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Fallston General Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Fallston
9c. COUNTY OF DEATH: Harford

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Harford
10c. CITY, TOWN OR LOCATION: Jarrettsville
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 3933 Federal Hill Road
10f. ZIP CODE: 21084
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Caucasian
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4 or 5+): - -
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Final Assembly
16b. KIND OF BUSINESS/INDUSTRY: Aircraft
17. FATHER'S NAME (First, Middle, Last): Thomas Edwin Mason Sr.
18. MOTHER'S NAME (First, Middle, Maiden Surname): Cornelia Lee Bull
19a. INFORMANT'S NAME (Type/Print): Annabel M. Mason
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as #10
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Bethel Cemetery | DATE: 6/20
20c. LOCATION — City or Town, State: Madonna, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: M. Sheridan Kurtz III
22. NAME AND ADDRESS OF FACILITY: Kurtz Funeral Home Jarrettsville, Maryland

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	B. strep Bacteraemia, (Rt) Empyema.	5 days.
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Anasarca, cellulitis low. Extremities	3 yrs.
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Dehydration Renal failure, Hyperkalaemia.	5 days.
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Severe Hyponatraemia.
Generalised oedema with bilat. pleu Eff. unknown Etiology.
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [X]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: B D PAREKH MD
29c. LICENSE NUMBER: D18424
29d. DATE SIGNED (Month, Day, Year): June 15 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): B.D. PAREKH MD 1908 HARFORD ROAD FALLSTON MD 21047
31. DATE FILED (Month, Day, Year): JUN 19 1995
32. REGISTRAR'S SIGNATURE: Julia Sheridan Randall

DHMH-16 Rev 1/89

95 20299

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Katherine P. Muir			2. DATE OF DEATH (Month, Day, Year): June 10, 1995	3. TIME OF DEATH: 7:15 a. M
4. SOCIAL SECURITY NUMBER: 214-60-8305	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 87 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Aug. 12, 1907	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Edw. W.McCready Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Crisfield		9c. COUNTY OF DEATH: Somerset

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Somerset	10c. CITY, TOWN OR LOCATION: Crisfield	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 213 N. Somerset Avenue		10f. ZIP CODE: 21817	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): H. S. Graduate; College (1-4 or 5+): - - -	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Co-Owner	16b. KIND OF BUSINESS/INDUSTRY: Florist	
17. FATHER'S NAME (First, Middle, Last): Thomas Parsons McKown		18. MOTHER'S NAME (First, Middle, Maiden Surname): Nellie Milbourne	
19a. INFORMANT'S NAME (Type/Print): Frances J. Dize		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 308 Somers Cove Apts.- Crisfield, MD 21817	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Sunnyridge Memorial Park-6/15/95	DATE	20c. LOCATION — City or Town, State: Crisfield, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert H. Bradshaw, Jr.		22. NAME AND ADDRESS OF FACILITY: Bradshaw & Sons Funeral Home 306 W. Main St.- Crisfield, MD 21817	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	e. CVA	Acute
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF):	
	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURED
			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
M. B. Barhan	12764	6/10/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. M. Barhan, Rt. 413, Crisfield, Md. 21817

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 15 1995	Julia Davidson-Randall

DHMH-16 Rev 1/89

95 20300

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mary Ann Magiera			2. DATE OF DEATH (Month, Day, Year): June 11 1995	3. TIME OF DEATH: 2:30 A M
4. SOCIAL SECURITY NUMBER: 155-03-7894	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 87 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Sept. 25, 1907	8. BIRTHPLACE (State or Foreign Country): New Jersey
9a. FACILITY NAME (If not institution, give street and number): Alice Byrd Tawes Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: Crisfield, MD	9c. COUNTY OF DEATH: Somerset	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Somerset	10c. CITY, TOWN OR LOCATION: Crisfield	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 4 Village Dr.- Apt. 22- Somerset Village		10f. ZIP CODE: 21817	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Grade 8; College (1-4 or 5+): — — —	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): Frank Czajkowski		18. MOTHER'S NAME (First, Middle, Maiden Surname): Eve Czajkowska
19a. INFORMANT'S NAME (Type/Print): Stanley A. Mageria (Son)		19b. MAILIND ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7480 River Road - Westover, MD 21871
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): St. Mary's of Ostrabrama Cem. DATE: 6/16/95	20c. LOCATION — City or Town, State: East Brunswick, N. J.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert H. Bradshaw, Jr.		22. NAME AND ADDRESS OF FACILITY: Bradshaw & Sons Funeral Home 306 W. Main St.- Crisfield, MD 21817

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Brain Tumor	2 months
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ ND	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ ND	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: James A. Sterling, MD	29c. LICENSE NUMBER: D10214	29d. DATE SIGNED (Month, Day, Year): 6-12-95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): James A. Sterling, M.D.- 320 W. Main St. - Crisfield, MD 21817		
31. DATE FILED (Month, Day, Year): JUN 15 1995	32. REGISTRAR'S SIGNATURE: Jean Davidson-Randall	

DHMH-16 Rev 1/89

95 20301

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Virginia Cameron Magaha			2. DATE OF DEATH (Month, Day, Year): June 15 1995	3. TIME OF DEATH: 11:05p M
4. SOCIAL SECURITY NUMBER: 217-42-9422	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 87 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): July 26, 1907	8. BIRTHPLACE (State or Foreign Country): Wash. CO MD
9a. FACILITY NAME (If not institution, give street and number): North Hampton Manor Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick	9c. COUNTY OF DEATH: Frederick	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Jefferson	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3819 Jefferson Pike		10f. ZIP CODE: 21755	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Housewife	
17. FATHER'S NAME (First, Middle, Last): Edward Guy Gittings		18. MOTHER'S NAME (First, Middle, Maiden Surname): Jennie Ann Elgin	
19a. INFORMANT'S NAME (Type/Print): Eugene F. Magaha		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 301 Franklin St., Middletown, MD 21769	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery, Crematory, other place): Pleasant View Church of the Brethren	DATE: June 19	20c. LOCATION — City or Town, State: Burkittsville MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Barbara A. Williams, Owner		22. NAME AND ADDRESS OF FACILITY: John T. Williams Funeral Home 100 Petersville Rd., Brunswick MD	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Congestive heart failure	years
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Diabetes mellitus	year
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, previous cerebrovascular accident

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Kathleen W Stern MD	29c. LICENSE NUMBER: D32073	29d. DATE SIGNED (Month, Day, Year): 6/16/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 610 Ninth Ave, Brunswick, Md. 21716 Kathleen W. Stern MD		
31. DATE FILED (Month, Day, Year): JUN 19 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall	

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 20302

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 6876, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): John Getzdanner Minnick

2. DATE OF DEATH Month: June Day: 5, Year: 1995

3. TIME OF DEATH: 2:45 P. M

4. SOCIAL SECURITY NUMBER: 217-01-0671

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 89 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): Nov. 10, 1905

8. BIRTHPLACE (State or Foreign Country): Md.

9a. FACILITY NAME (If not institution, give street and number): Frederick Healthcare Center

9b. CITY, TOWN OR LOCATION OF DEATH: Frederick

9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Md.

10b. COUNTY: Frederick

10c. CITY, TOWN OR LOCATION: Middletown

10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER: 3430 Roy Shafer Rd.

10f. ZIP CODE: 21769

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 4 | College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): carpenter

16b. KIND OF BUSINESS/INDUSTRY: construction

17. FATHER'S NAME (First, Middle, Last): Jacob D. Minnick

18. MOTHER'S NAME (First, Middle, Maiden Surname): Cora S. Getzdanner

19a. INFORMANT'S NAME (Type/Print): Leonard J. Minnick

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3430 Roy Shafer Rd., Middletown, Md. 21769

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Reformed Cemetery | DATE: 5/8

20c. LOCATION — City or Town, State: Middletown, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald B Thompson

22. NAME AND ADDRESS OF FACILITY: Donald B. Thompson Funeral Home, 31 E. Main St., Middletown, Md. 21769

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia — 3-4 wks

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. _____ DUE TO (OR AS A CONSEQUENCE OF):

c. _____ DUE TO (OR AS A CONSEQUENCE OF):

d. _____

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: W. Wayne M.D.

29c. LICENSE NUMBER: D16675

29d. DATE SIGNED (Month, Day, Year) ▶ 6/22/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): WAYNE ALDAMER, BRUNSWICK, MD 21716

31. DATE FILED (Month, Day, Year): JUN 23 1995

32. REGISTRAR'S SIGNATURE: Julia Sheridan Randall

DHMH-16 Rev 1/89

AMENDED 6.20.95
#7/att.

95 20303

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DOROTHY F. MANDERY			2. DATE OF DEATH: Month June, Day 12, Year 1995	3. TIME OF DEATH: 5:30 P M
4. SOCIAL SECURITY NUMBER: 103-18-4995	5. SEX: 1 ☐ M 2 ☒ F	8. AGE (In yrs. last birthday): 85 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): March 12, ~~1920~~ 1910	8. BIRTHPLACE (State or Foreign Country): Massachusetts
9a. FACILITY NAME (If not institution, give street and number): Annapolis Nursing & Rehab. Center		9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis		9c. COUNTY OF DEATH: Anne Arundel
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Annapolis		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 780 Fairview Avenue		10f. ZIP CODE: 21403		10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Order Clerk		16b. KIND OF BUSINESS/INDUSTRY: Brokerage
17. FATHER'S NAME (First, Middle, Last): John Coughlin		18. MOTHER'S NAME (First, Middle, Maiden Surname): Lucy Griffin		
19a. INFORMANT'S NAME (Type/Print): Barbara Grube		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2 Longwood Ter. Ct., Rehobeth Beach, Del. 19971		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Calvary Cemetery 6/15/95	DATE	20c. LOCATION — City or Town, State: Dorchester, Mass.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James M. Taylor		22. NAME AND ADDRESS OF FACILITY: John M. Taylor Funeral Home, 147 Duke of Gloucester St. Annapolis, Md.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Failure to Thrive	3 years
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. —	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. —	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. —	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Major depression, chronic pain in right leg

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Charles W. Kinzer	29c. LICENSE NUMBER: D05928	29d. DATE SIGNED (Month, Day, Year): ▶ June 13, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles W. Kinzer, M.D. 1833-A Forest Dr. Annapolis, Md. 21401 (410-267-9211)		
31. DATE FILED (Month, Day, Year): JUN 20 1995	32. REGISTRAR'S SIGNATURE: Julia Anderson Bartell	

DHMH-18 Rev 1/89

95 20304

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ROBERT H. NORTH			2. DATE OF DEATH (Month, Day, Year): JUNE 13, 1995	3. TIME OF DEATH: 12:15 AM
4. SOCIAL SECURITY NUMBER: 577-38-1422	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 83 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): December 22, 1911	8. BIRTHPLACE (State or Foreign Country): Spooner, WI
9a. FACILITY NAME (If not institution, give street and number): SUBURBAN HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BETHESDA		9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Bethesda	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 5905 Tanglewood Drive		10f. ZIP CODE: 20817	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 6	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Executive	16b. KIND OF BUSINESS/INDUSTRY: Trade Association	
17. FATHER'S NAME (First, Middle, Last): Robert H. North		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mabel Miller	
19a. INFORMANT'S NAME (Type/Print): Charles A. Hass	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6743 Fern Lane, Annandale, VA 22003		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Shell Lake Cemetery	DATE: 6/19/95	20c. LOCATION — City or Town, State: Shell Lake, WI
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: Rendon/Hale Lanham Funeral Home 9013 Annapolis Road, Lanham, MD 20706		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Multiple organ failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Sepsis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [X]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY; 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO; 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Alan Kravitz MD	29c. LICENSE NUMBER: D33295	29d. DATE SIGNED (Month, Day, Year): 6/13/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Alan Kravitz MD 5822 Shields Drive Bethesda Md. 20817		
31. DATE FILED (Month, Day, Year): JUN 16 1995	32. REGISTRAR'S SIGNATURE: John Davidson-Randall	

DHMH-18 Rev 1/89

95 20305

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1071

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MELVIN ALBERT NEUTZE			2. DATE OF DEATH (Month, Day, Year): June 18 1995	3. TIME OF DEATH: 9:50 AM
4. SOCIAL SECURITY NUMBER: 218-07-0381	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 77 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): March 11, 1918	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Bel Forest Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: Forest Hill		9c. COUNTY OF DEATH: Harford
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Forest Hill		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO
10e. STREET AND NUMBER: 2513 Putnam Road		10f. ZIP CODE: 21050		10g. CITIZEN OF WHAT COUNTRY? U S A
11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Mail Clerk	16b. KIND OF BUSINESS/INDUSTRY: U.S. Postal Service		
17. FATHER'S NAME (First, Middle, Last): John -- Neutze		18. MOTHER'S NAME (First, Middle, Maiden Surname): Selma --- Ulrich		
19a. INFORMANT'S NAME (Type/Print): Flora M. Neutze		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2513 Putnam Rd. Forest Hill, Maryland 21050		
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place): Parkwood Cemetery DATE: June21,95	20c. LOCATION — City or Town, State: Baltimore, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: Howard K. McComas III Funeral Home P.A. 1317 Cokesbury Road Abingdon, Maryland 21009			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Brain Cancer, Glioblastoma	4 months
DUE TO (OR AS A CONSEQUENCE OF): b.	Pneumonia	Terminal
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	Dehydration	Terminal
DUE TO (OR AS A CONSEQUENCE OF): d.	Coma	Terminal

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☑ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]

29c. LICENSE NUMBER: D16389

29d. DATE SIGNED (Month, Day, Year): ▶ 6/19/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Perfecto C. Valarao M.D. 1716 Harford Rd, Fallston MD 21078

31. DATE FILED (Month, Day, Year): JUN 20 1995

32. REGISTRAR'S SIGNATURE: Julia Sheridan Randall

DHMH-18 Rev 1/89

95 20306

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William Walter Nott, Sr.		2. DATE OF DEATH (Month, Day, Year): June 17, 1995	3. TIME OF DEATH: 6:00 A M
4. SOCIAL SECURITY NUMBER: 162-22-7612	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 85 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Feb 12, 1910
8. BIRTHPLACE (State or Foreign Country): Maryland			
9a. FACILITY NAME (If not institution, give street and number): Carroll County General Hosp	9b. CITY, TOWN OR LOCATION OF DEATH: Westminster	9c. COUNTY OF DEATH: Carroll	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Millers	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 19601 Gunpowder Road	10f. ZIP CODE: 21107	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Self Employed	16b. KIND OF BUSINESS/INDUSTRY: Farmer	
17. FATHER'S NAME (First, Middle, Last): George C. Nott	18. MOTHER'S NAME (First, Middle, Maiden Surname): Rosa Hare		
19a. INFORMANT'S NAME (Type/Print): Machree Nott	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 19601 Gunpowder Rd, Millers, MD 21107		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Carroll Cremations DATE: 6/18	20c. LOCATION — City or Town, State: Hampstead, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Steven W. Eline	22. NAME AND ADDRESS OF FACILITY: Eline Funeral Home 934 S Main St, Hampstead, MD 21074		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Spontaneous Pneumothorax	1 day
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Pleural effusion	"
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Malnutrition

Protein loosing enteropathy

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH? YES [ ] NO [X] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] ND	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] ND	26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] ND; 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD	29c. LICENSE NUMBER: D40235	29d. DATE SIGNED (Month, Day, Year): ▶ June/19/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Kim, Carroll County Gen Hos- 200 Memorial Ave, Westminster, MD		
31. DATE FILED (Month, Day, Year): JUN 20 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson Rockell	

DHMH-16 Rev 1/89

95 20307

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Martin Patrick NEAREY
2. DATE OF DEATH (Month, Day, Year): June 14, 1995
3. TIME OF DEATH: 7:55 PM M
4. SOCIAL SECURITY NUMBER: 192-16-5263
5. SEX: 1 XX M 2 ☐ F
6. AGE (In yrs. last birthday): 70 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Dec. 4, 1924
8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): 8906 Knollwood Way
9b. CITY, TOWN OR LOCATION OF DEATH: Frederick
9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Frederick
10c. CITY, TOWN OR LOCATION: Frederick
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 XX NO
10e. STREET AND NUMBER: 8906 Knollwood Way
10f. ZIP CODE: 21701
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: Mar. 8, 1946-Mar. 30, 1947
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Type Setter
16b. KIND OF BUSINESS/INDUSTRY: Printing
17. FATHER'S NAME (First, Middle, Last): Bernard NEAREY
16. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Elizabeth SULLIVAN
19a. INFORMANT'S NAME (Type/Print): Mrs. Clara Marie Nearey
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8906 Knollwood Way, Frederick, Md. 21701
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Gate of Heaven Cemetery — DATE: June 17, 1995
20c. LOCATION — City or Town, State: Silver Spring, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Richard E. Gray M00255
22. NAME AND ADDRESS OF FACILITY: Keeney and Basford P.A. Funeral Home, 106 East Church St., Frederick, Md. 21701

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Resp. Failure	14 June 95
DUE TO (OR AS A CONSEQUENCE OF): b.	Pneumonia	June 95
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	Recurrent CVA	Dec 94
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Gastric Malignancy
Diabetes Mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO X UNCERTAIN ☐

25. WAS CASE REFERRED TO MEOICAL EXAMINER? 1 ☐ YES 2 X NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEOICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Casagrande
29c. LICENSE NUMBER: D 40307
29d. DATE SIGNED (Month, Day, Year): ▶ June 15, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Eugene B. Casagrande MD 1564 Opossumtown Pike, Frederick, Maryland 21702
31. DATE FILED (Month, Day, Year): JUN 16 1995
32. REGISTRAR'S SIGNATURE: Julia Dinsmore Randall

DHMH-16 Rev 1/89

ITEMS: 23 PART I, II, PER MEO FILM G-726 8/10/95 t.t

95 20308

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Cheryl Lynn Neal				2. DATE OF DEATH (Month, Day, Year): June 18, 1995	3. TIME OF DEATH: 2115 M
4. SOCIAL SECURITY NUMBER: 415-86-2212	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 44 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Dec. 21, 1950	8. BIRTHPLACE (State or Foreign Country): Washington, D.C
9a. FACILITY NAME (If not institution, give street and number): Southern Maryland Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Clinton		9c. COUNTY OF DEATH: Prince George's
RESIDENCE OF DECEDENT					
10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Upper Marlboro			10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 9619 Midland Turn		10f. ZIP CODE: 20772		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES X	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Caucasian	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Administrative Assistant		16b. KIND OF BUSINESS/INDUSTRY: Office of Naval Intelligence	
17. FATHER'S NAME (First, Middle, Last): Robert Morton			18. MOTHER'S NAME (First, Middle, Maiden Surname): Anne Pogue		
19a. INFORMANT'S NAME (Type/Print): Billy E. Neal		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9619 Midland Turn Upper Marlboro, Md 20772			
20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland State Veterans Cem. DATE: June 21, 1995		20c. LOCATION — City or Town, State: Cheltenham, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, Maryland 20735			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	years
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Kidney Problems removed, Angina

DISCOID LUPUS ERYTHEMATOSIS

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☒ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Augusto P. Rodriguez MD

29c. LICENSE NUMBER: D21230

29d. DATE SIGNED (Month, Day, Year): June 18, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Augusto P. Rodriguez MD, 5009 Roysburn Ct. Cp Spr. Md 20745

31. DATE FILED (Month, Day, Year): JUN 20 1995

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DNMN-16 Rev 1/89

95-3431-033
B.K.S

95 20309

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARIE Mable OWEN					2. DATE OF DEATH (Month, Day, Year): JUNE 11, 1995	3. TIME OF DEATH: 5:00 PM
4. SOCIAL SECURITY NUMBER: 516-50-3347	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 49 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Sept. 19, 1945	8. BIRTHPLACE (State or Foreign Country): Montana
9a. FACILITY NAME (If not institution, give street and number): PRINCE GEORGES HOSPITAL CENTER			9b. CITY, TOWN OR LOCATION OF DEATH: CHEVERLY		9c. COUNTY OF DEATH: PRINCE GEORGES	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Suitland	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3809 Swann Road # T-3		10f. ZIP CODE: 20746-2242	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Caucasian

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): N/A	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Head Cashier	16b. KIND OF BUSINESS/INDUSTRY: N.C.O. Club Bolling Air Force Base	
17. FATHER'S NAME (First, Middle, Last): Edward Joseph Galarneau		18. MOTHER'S NAME (First, Middle, Maiden Surname): Joyce Marie Ardis	
19a. INFORMANT'S NAME (Type/Print): Sarah M. Lambert		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3036 Fredrick St. N Las Vegas NV 89030	

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Lee Crematory June	DATE: ,1995	20c. LOCATION — City or Town, State: Clinton, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, Md 20735		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Multiple Injuries	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 6-11-95	28b. TIME OF INJURY: 1420 M	28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO	28d. DESCRIBE HOW INJURY OCCURED: Driver - fixed object collision
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Roadway			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): South bend Rd P.G. Co.

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: O.C.M.E	29d. DATE SIGNED (Month, Day, Year): ▶ JUNE 12, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): David R Fowler	111 Penn Street, Baltimore, Maryland 21201	
31. DATE FILED (Month, Day, Year): JUN 20 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

AMENDED #20b #20c 6/14/95 ELM P.G.C.

95 20310

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEOENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month / Day / Year)	3. TIME OF DEATH
DEBORAH	TERRY	PARKER	JUNE 8 1995	6:10 a M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
242-02-2351	1 ☐ M 2 ☒ F XX	39 YRS.			8-19-55	N.C.

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
WASHINGTON ADVENTIST HOSPITAL	TAKOMA PARK	Montgomery

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MD.	Prince Georges	District Heights	1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
4720 HURON ST	20747	U.S.A?

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced XX	1 ☐ YES 2 ☒ NO XX	1 ☐ YES ☒ NO Specify:	Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5 +)		
9th		MAINTENANCE	NURSING HOME

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
CHARLES TERRY	NELLIE SPAIN

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
NELLIE BEST	6925 Halleck ST. District HGTS MD 20747

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) XX	~~HARMONY MEMORIAL PARK~~ Woodlawn Cemetery 6/12	~~LANDOVER MD~~ Washington, D.C.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Jack Pollard Jr	MODERN FUNERAL HOME 3821 14th ST. N.W.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or reepiratory erreat, shock, or hesrt failure. List only one ceuse on each line.

		Approximate interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acquired immune deficiency syndrome	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

pneumonia thrombocytopenia purpura

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☒ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
1 ☐ YES 2 ☒ NO	

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)

1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] MD	D01499	▶ June 8, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print)

D.R. Lewis Dennis 6201 Greenbelt Rd. College Park, MD. 20740

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 14 1995	Julia Davidson Randall

DHMH-16 Rev 1/89

(1)

95-3360-033
B.K.S

ITEMS: 23 PART I, 27,28a-f, PER MEO FILM G-725 7/19/95 t.t

95 20311

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
REGGINALD PRITCHETT		JUNE 8, 1995	6:31 A M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
577-96-9621	1 ☒ M 2 ☐ F	31 YRS.			July 10,1963	Danville,VA

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
PRINCE GEORGES HOSPITAL CENTER	CHEVERLY	PRINCE GEORGES

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Prince George's	Landover	1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
7744 Normady Road	20785	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES?	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	1 ☐ YES 2 ☒ ND Specify:	Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
	4 years	Word Processor	Private

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
James Pritchett	Laura McLaughlin

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
James Pritchett	7744 Normady Road, Landover, Maryland 20785

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other piece)	DATE	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Harmony Memorial Park	6/14/1995	Landover, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Suawana L. Braxton	J.B. JENKINS FUNERAL HOME 7474 Landover Rd, Landover, MD 20785

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. GUNSHOT WOUND OF CHEST, CONTACT	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): b.	
	DUE TO (OR AS A CONSEQUENCE OF): c.	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☒ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
☒ YES 2 ☐ NO	HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☐ Natural 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	6-8-95	2:20 A M	1 ☐ YES 2 ☒ NO	SUBJECT SHOT SELF

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
HOME	7744 NORMANDY ROAD HYATTSVILLE, MD.

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Mario F. Golle Jr. M.D.	O.C.M.E	▶JUNE 8,1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Mario F. Golle Jr. M.D. 111 Penn Street, Baltimore, Maryland 21201

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 13 1995	Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95-3337-033
ML

95 20312

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EDWIN PAUL PINKNEY			2. DATE OF DEATH (Month, Day, Year): JUNE 06 1995	3. TIME OF DEATH: 7:18 PM
4. SOCIAL SECURITY NUMBER: 578-80-6265	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 31 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): June 25,1963	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): PRINCE GEORGES HOSPITAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: CHEVERLY		9c. COUNTY OF DEATH: PRINCE GEORGES
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Capitol Heights		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 5803 Cooledge Street		10f. ZIP CODE: 20743		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Landscaping		16b. KIND OF BUSINESS/INDUSTRY: Private
17. FATHER'S NAME (First, Middle, Last): Earl Pinkney			18. MOTHER'S NAME (First, Middle, Maiden Surname): Florence Thomas	
19a. INFORMANT'S NAME (Type/Print): Florence Pinkney		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5803 Cooledge St. Capitol Heights, MD. 20743		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place): Harmony Memorial Park	DATE: Jun 12	20c. LOCATION — City or Town, State: Landover, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FACILITY: J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, MD20785		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pulmonary Thrombo-embolism	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic pancreatitis
Chronic alcoholism

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [X]

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Dennis J. Chute MD	O.C.M.E.	▶ JUNE 07,1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DENNIS J. CHUTE 111 Penn Street, Baltimore, Maryland 21201

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 13 1995	Julia Davidson Rudolph

5

DHMH-18 Rev 1/89

95 20313

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Elijah St. George PELHAM			2. DATE OF DEATH (Month, Day, Year): June 5, 1995	3. TIME OF DEATH: 10:15P M
4. SOCIAL SECURITY NUMBER: 237-38-9582	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 65 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): March 31, 1930	8. BIRTHPLACE (State or Foreign Country): North Carolina
9a. FACILITY NAME (If not institution, give street and number): Doctors Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Lanham		9c. COUNTY OF DEATH: Prince George's

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Upper Marlboro	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 12809 Peachleaf Court		10f. ZIP CODE: 20772	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Construction Worker	16b. KIND OF BUSINESS/INDUSTRY: Private	
17. FATHER'S NAME (First, Middle, Last): Joseph Robinson		18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret Pelham	
19a. INFORMANT'S NAME (Type/Print): Ola Pelham	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12809 Peachleaf Ct. Upper Marlboro, Md. 20772		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Pelham Cemetery	DATE: Jun 12	20c. LOCATION — City or Town, State: Maco, North Carolina
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Kimberly C Briscoe-Eric	22. NAME AND ADDRESS OF FACILITY: J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, MD. 20785		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CARDIO PULMONARY ARREST	immed.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. CARCINOMATOSIS	7 mos
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. CARCINOMA OF LUNG	7 mos
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Atherosclerotic Cardio Vascular Disease

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Mehdi Farzin	29c. LICENSE NUMBER: D04841	29d. DATE SIGNED (Month, Day, Year): 6-6-95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MEHDI P FARZIN 7525 Greenway CTR DR Greenbelt MD 20770

31. DATE FILED (Month, Day, Year): JUN 13 1995	32. REGISTRAR'S SIGNATURE: John Davidson Registrar

DHMH-16 Rev 1/89

(10)

95 20314

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RICHARD PRESGRAVES			2. DATE OF DEATH (Month, Day, Year): 6 / 10 / 95	3. TIME OF DEATH: 1108p M
4. SOCIAL SECURITY NUMBER: 228-38-3317	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 60 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): August 4, 1934	8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): John's Hopkins Bayview Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore (City)		9c. COUNTY OF DEATH: None

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: None	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 818 South Eaton Street		10f. ZIP CODE: 21224	10g. CITIZEN OF WHAT COUNTRY?: United States of America

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: After 1955	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Florist	16b. KIND OF BUSINESS/INDUSTRY: Retail Flower Shop	
17. FATHER'S NAME (First, Middle, Last): Virgil Bryan Presgraves		18. MOTHER'S NAME (First, Middle, Maiden Surname): Wilhelmina Gertrude Johnson	
19a. INFORMANT'S NAME (Type/Print): Doris L. Lillard		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): State Route 611, Luray, Virginia 22835	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Presgraves Family Cemetery DATE: 6/14/1995	20c. LOCATION — City or Town, State: Luray, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: #M00690 Howard D Carson		22. NAME AND ADDRESS OF FACILITY: The Bradley Funeral Home, 187 East Main Street, Luray, VA	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Acute Renal Failure	48 hrs
DUE TO (OR AS A CONSEQUENCE OF): b.	Fulminant Hepatic Failure	10 days
DUE TO (OR AS A CONSEQUENCE OF): c.	Alcoholic Hepatitis	2-5 years
DUE TO (OR AS A CONSEQUENCE OF): d.		

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA. OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Howard Ian Savage MD	29c. LICENSE NUMBER: 25013	29d. DATE SIGNED (Month, Day, Year): ▶ 6/10/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): HOWARD IAN SAVAGE, MD 494C Eastern Ave.

31. DATE FILED (Month, Day, Year): JUN 15 1995	32. REGISTRAR'S SIGNATURE: Julia Strickler Randall

(4)

DHMH-16 Rev 1/89

95 20315

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Samuel Clifford PITTINGER			2. DATE OF DEATH: MONTH 6 / DAY 18 / YEAR 95	3. TIME OF DEATH: 00:48 A M
4. SOCIAL SECURITY NUMBER: 214160405	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 81 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 03-11-14	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): CARROLL CO GEN HOSP - 200 MEMORIAL		9b. CITY, TOWN OR LOCATION OF DEATH: WESTMINSTER, MD		9c. COUNTY OF DEATH: CARROLL
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY: CARROLL	10c. CITY, TOWN OR LOCATION: WESTMINSTER		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1818 OLD TANEYTOWN RD.		10f. ZIP CODE: 21158		10g. CITIZEN OF WHAT COUNTRY?: USA.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MACHINE OPERATOR	16b. KIND OF BUSINESS/INDUSTRY: MANUFACTURING		
17. FATHER'S NAME (First, Middle, Last): SAMUEL BELL PITTINGER		18. MOTHER'S NAME (First, Middle, Maiden Surname): ELLA MARGARET KRESS		
19a. INFORMANT'S NAME (Type/Print): RUTH O. BEARD-WALL	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 327 SEMINARY AVE., LUTHERVILLE, MD. 21093			
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery, Crematory or Other Place): MEADOW BRANCH CEM. — DATE: 6/21/95	20c. LOCATION — City or Town, State: WESTMINSTER, MD.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: FLETCHER FUNERAL HOME 254 E. MAIN ST. WESTMINSTER, MD. 21157			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Ventricular Fibrillation	MINS
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): b. dilated ischemic Cardiomyopathy	3 MONTHS
	DUE TO (OR AS A CONSEQUENCE OF): c.	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Severe COPD, Hypertension, DJD
acid peptic Disease

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [X] NO [ ] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D 23015	29d. DATE SIGNED (Month, Day, Year): 6/18/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DINESH KALARIA 217 WASHINGTON HGTS WESTMINSTER MD 21157

31. DATE FILED (Month, Day, Year): JUN 20 1995	32. REGISTRAR'S SIGNATURE: [signature]

DHMH-18 Rev 1/89

95 20316

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Sarah Marie ROBERTS				2. DATE OF DEATH: MONTH June DAY 12, YEAR 1995	3. TIME OF DEATH: 5:19 A. M
4. SOCIAL SECURITY NUMBER: 212 17 7788	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 9 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): March 30, 1986	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Doctors' Community Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Lanham		9c. COUNTY OF DEATH: Prince George's

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Bowie		10d. INSIDE CITY LIMITS? ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 11233 Westport Drive		10f. ZIP CODE: 20720		10g. CITIZEN OF WHAT COUNTRY? United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 4 / College (1-4 or 5 +):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Student		16b. KIND OF BUSINESS/INDUSTRY: School
17. FATHER'S NAME (First, Middle, Last): James Roberts		18. MOTHER'S NAME (First, Middle, Maiden Surname): Sharon Pearson		
19a. INFORMANT'S NAME (Type/Print): James Roberts		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11233 Westport Drive Bowie Maryland 20720		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): St. Pauls Episcopal Church Cemetery	DATE	20c. LOCATION — City or Town, State: 6/15/95 Waldorf Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert E. Evans Pres.		22. NAME AND ADDRESS OF FACILITY: Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cerebral Palsy with sepsis	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Augusto P. Rodriguez MD	D21230	June 12, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Augusto P. Rodriguez MD, 5009 Laytonsville Ct. Spl MD 20748

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 14 1995	Julia Davidson-Rodell

DHMH-16 Rev 1/89

95 20317

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
SYLVIA	D	ROWE	JUNE 11 95	11:40 A M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
578-82-6237	1 ☐ M 2 ☒ F	33 YRS.			Feb.1,1962	Wash.D.C.

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Prince Georges Hospital	Cheverly	PRINCE GEORGE'S

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Prince Georges	Landover Hills	1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
3839 64th Ave. #402	20784	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
10		Food Service	Marriott Corp.

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Calvin Rowe	Lillian D. Shaw

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Calvin Rowe Father	4923 55th Pl.Hyattsville,Md.20781

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place)	DATE	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)	Lincoln Memorial Cem.	6/16	Suitland,Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ F. Bernard Hunt	Hunt Funeral Home 1420 34th St.S.E.Wash.D.C.20020

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. BILATERAL PULMONARY ARTERIAL	
DUE TO (OR AS A CONSEQUENCE OF):	THROMBO-EMBOLISM	minutes
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
☒ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
J Berger MD	D25925	▶ June 12, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
J. BERGER MD #205, 7720 WISCONSIN Ave, Bethesda, Md 20814

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 14 1995	Marlene Nardell

DHMH-16 Rev 1/89

(2)

95 20318

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Joseph Leon Randolph			2. DATE OF DEATH (Month, Day, Year): June 8, 1995	3. TIME OF DEATH: 445 A M
4. SOCIAL SECURITY NUMBER: 579-05-4935	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 75 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): OCT. 14, 1919	8. BIRTHPLACE (State or Foreign Country): WASHINGTON, D. C.
9a. FACILITY NAME (If not institution, give street and number): 5604 HELMONT PLACE		9b. CITY, TOWN OR LOCATION OF DEATH: OXON HILL	9c. COUNTY OF DEATH: P. G.	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: P. G.	10c. CITY, TOWN OR LOCATION: OXON HILL	10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: 5604 HELMONT PLACE		10f. ZIP CODE: 20745	10g. CITIZEN OF WHAT COUNTRY?: U. S. A.

11. MARITAL STATUS: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: 15 JUL 43-11 FEB, 46	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12):	College (1-4 or 5+): 1 YR	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): STATISTICIAN	16b. KIND OF BUSINESS/INDUSTRY: G. S. A.
17. FATHER'S NAME (First, Middle, Last): GEORGE G. RANDOLPH, SR.		18. MOTHER'S NAME (First, Middle, Maiden Surname): MAMIE PENDELTON	
19a. INFORMANT'S NAME (Type/Print): CECELIA B. FORREST		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5604 HELMONT PL. OXON HILL, MD 20745	
20a. METHOD OF DISPOSITION: X 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): MT. OLIVET CEMETERY	DATE: 6/12	20c. LOCATION — City or Town, State: WASHINGTON, D. C.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Theodore C. Pinckney		22. NAME AND ADDRESS OF FACILITY: PINCKNEY-SPANGLER FUNERAL HOME 524 - 8TH ST., N. E. WASH., D. C. 20002	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heert failure. List only one cause on esch line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	Hypertensive arteriosclerotic cardiovascular disease	Years
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — a.		
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I.: Parkinson's Disease

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☑ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☑ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☑ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☑ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: August P. Rodriguez MD	29c. LICENSE NUMBER: D7730	29d. DATE SIGNED (Month, Day, Year): June 8, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): August P. Rodriguez MD, 5009 Roy Turner Ct. Oxon Hill MD 20745

31. DATE FILED (Month, Day, Year): JUN 12 1995	32. REGISTRAR'S SIGNATURE: John Davidson-Randall

DHMH-18 Rev 1/89

95 20319

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ARCHIE DEAN ROBINSON			2. DATE OF DEATH: MONTH June DAY 11 YEAR 1995	3. TIME OF DEATH: 4:50p M
4. SOCIAL SECURITY NUMBER: 237-76-5854	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 45 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): June 26, 1949	8. BIRTHPLACE (State or Foreign Country): North Carolina
9a. FACILITY NAME (If not institution, give street and number): 9908 Jacquelinee Drive			9b. CITY, TOWN OR LOCATION OF DEATH: Fort Washington	9c. COUNTY OF DEATH: Prince George's
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Fort Washington		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 9908 Jacqueline Drive		10f. ZIP CODE: 20744		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Nursing Assistant		16b. KIND OF BUSINESS/INDUSTRY: Private
17. FATHER'S NAME (First, Middle, Last): Morris Wade, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Robertha McGuire		
19a. INFORMANT'S NAME (Type/Print): Laura Robinson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9908 Jacqueline Dr. Fort Washington, Md 20744		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place): Cowels Church Cemetery	DATE: Jun15	20c. LOCATION — City or Town, State: Scotlandneck, North Carolina	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Shawana L Braxton	22. NAME AND ADDRESS OF FACILITY: J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, Md 20785			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acquired IMMUNE DEFICIENCY SYNDROME	years
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	a. DUE TO (OR AS A CONSEQUENCE OF):	
	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURED
			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Cesar Soriano MD	29c. LICENSE NUMBER: D 44468	29d. DATE SIGNED (Month, Day, Year) ▶ 6/12/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): CESAR SORIANO JR., M.D., P.A. 119 Capitol Heights Blvd. Capitol Heights, MD 20743-6298 Tel. (301) 336-4060

31. DATE FILED (Month, Day, Year): JUN 13 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

95 20320

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Brian Arthur Ramsey			2. DATE OF DEATH (Month, Day, Year): June 16, 1995	3. TIME OF DEATH: 7:47 A M
4. SOCIAL SECURITY NUMBER: 313-40-2353	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 50 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Aug. 24, 1944	8. BIRTHPLACE (State or Foreign Country): Indiana
9a. FACILITY NAME (If not institution, give street and number): Physicians Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: La Plata		9c. COUNTY OF DEATH: Charles
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Charles	10c. CITY, TOWN OR LOCATION: Charlotte Hall		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 7705 Kent Drive		10f. ZIP CODE: 20622		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: 1961-1967	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Owner/Operator		16b. KIND OF BUSINESS/INDUSTRY: Construction Comp.
17. FATHER'S NAME (First, Middle, Last): Unavailable		18. MOTHER'S NAME (First, Middle, Maiden Surname): Charlotte Rozcicha		
19a. INFORMANT'S NAME (Type/Print): Judith Heberle Ramsey		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7705 Kent Dr. Charlotte Hall, Maryland 20622		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Resurrection Cemetery	DATE: 6/20	20c. LOCATION — City or Town, State: Clinton, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: BMM▶ Mark G. Brohawn M-00053		22. NAME AND ADDRESS OF FACILITY: The Huntt Funeral Home, Inc. P.O. Box 156 Waldorf, Maryland 20604		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arreat, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic Cardiovascular Disease	years
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURED
			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] Deputy ME	29c. LICENSE NUMBER: D27348	29d. DATE SIGNED (Month, Day, Year): ▶ 6/17/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): [illegible] P.O Box 1677 Waldorf MD 20603		
31. DATE FILED (Month, Day, Year): JUN 21 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall	

DHMH-16 Rev 1/89

95 20321

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): AUDREY KATHERINE RIMMER			2. DATE OF DEATH (Month, Day, Year): June 18, 1995	3. TIME OF DEATH: 6:30 p M
4. SOCIAL SECURITY NUMBER: 579-01-5113	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 80 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Jan 19 1915	8. BIRTHPLACE (State or Foreign Country): PA
9a. FACILITY NAME (If not institution, give street and number): 2720 Bay Blvd		9b. CITY, TOWN OR LOCATION OF DEATH: Huntingtown		9c. COUNTY OF DEATH: Calvert
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY: Calvert	10c. CITY, TOWN OR LOCATION: Huntingtown		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 2720 Bay Blvd		10f. ZIP CODE: 20639		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 1	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife		16b. KIND OF BUSINESS/INDUSTRY: Own Home
17. FATHER'S NAME (First, Middle, Last): William C. Gladhill		18. MOTHER'S NAME (First, Middle, Maiden Surname): Charlotte Koons		
19a. INFORMANT'S NAME (Type/Print): William W. Rimmer		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 223 13th Street Brunswick, MD 21716		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan Crematory DATE 6-20-95		20c. LOCATION — City or Town, State: Alexandria, VA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: Rausch Funeral Home, PA Owings, MD 20736		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Atherosclerotic Cardiovascular Disease	1hr
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: S. Prouty MD

29c. LICENSE NUMBER: A49936

29d. DATE SIGNED (Month, Day, Year): 6/19/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Susan H. Prouty, MD Calvert Med. Arts Prince Frederick, MD 20736

31. DATE FILED (Month, Day, Year): JUN 20 1995

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

6

DHMH-18 Rev 1/89

95 20322

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Annie Laurie RIPPEON			2. DATE OF DEATH (Month, Day, Year): June 14, 1995	3. TIME OF DEATH: 1:18 A. M
4. SOCIAL SECURITY NUMBER: 215-20-8987	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 88 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): April 2, 1907	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 810 Cromwell Drive		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick		9c. COUNTY OF DEATH: Frederick
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Frederick		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 810 Cromwell Drive		10f. ZIP CODE: 21701		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4 or 5 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own home		
17. FATHER'S NAME (First, Middle, Last): Maurice Edward Ricketts		18. MOTHER'S NAME (First, Middle, Maiden Surname): Bertha Sodinia Warfield		
19a. INFORMANT'S NAME (Type/Print): Evangeline Ann Teitlebaum		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 810 Cromwell Drive, Frederick, Md. 21701		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Monocacy Cemetery	DATE: June 16, 1995	20c. LOCATION — City or Town, State: Beallsville, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Richard C. Basford M00021		22. NAME AND ADDRESS OF FACILITY: Keeney and Basford Funeral Home 106 East Church St., Frederick, Md. 21701		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such ee cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Emphysema	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.: Anemia

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	28. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Lloyd Halvorson	29c. LICENSE NUMBER: D22019	29d. DATE SIGNED (Month, Day, Year): June 14, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Lloyd E. Halvorson, M.D., 1475 Taney Ave., Frederick, Md. 21701		
31. DATE FILED (Month, Day, Year): JUN 16 1995	32. REGISTRAR'S SIGNATURE: John Davidson Randall	

DHMH-18 Rev 1/89

95 20323

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Bethany Laura Rowe			2. DATE OF DEATH (Month, Day, Year): June 16, 1995	3. TIME OF DEATH: 11:37P M
4. SOCIAL SECURITY NUMBER: 224-58-8968	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 52 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Feb. 26, 1943	8. BIRTHPLACE (State or Foreign Country): West Virginia
9a. FACILITY NAME (If not institution, give street and number): Southern Maryland Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Clinton		9c. COUNTY OF DEATH: Prince George's

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Charles	10c. CITY, TOWN OR LOCATION: Waldorf	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 7020 Evergreen Drive		10f. ZIP CODE: 20601	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Caucasian

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): N/A	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Administrative Secretary	16b. KIND OF BUSINESS/INDUSTRY: United Methodist Church	
17. FATHER'S NAME (First, Middle, Last): Charlie William Vest		18. MOTHER'S NAME (First, Middle, Maiden Surname): Gladys Elizabeth VanDyke	
19a. INFORMANT'S NAME (Type/Print): Lisa Rowe Deckert		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7020 Evergreen Dr. Waldorf, Md 20601	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Zion Brethren Ch. Cem. DATE: June 21, 1995	20c. LOCATION — City or Town, State: Stoney Man Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Charles L. Bélanger		22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, Md. 20735	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Parkinson's Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Bedridden or decubitus, diabetes mellitus, adiposity, back problem, asthma

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☑

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☑ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Augusto P. Rodriguez MD	29c. LICENSE NUMBER: D21230	29d. DATE SIGNED (Month, Day, Year): June 17, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Augusto P. Rodriguez MD, 5009 Raytheon Ct. Cp Hgts. Md 20748		
31. DATE FILED (Month, Day, Year): JUN 20 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall	

DHMH-16 Rev 1/89

95 20324

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Richard Dwight Rice				2. DATE OF DEATH (Month, Day, Year): June 14, 1995	3. TIME OF DEATH: 2:40 P M
4. SOCIAL SECURITY NUMBER: 220-28-9861	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 64 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Nov. 13, 1930	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Southern Maryland Hospital				9b. CITY, TOWN OR LOCATION OF DEATH: Clinton	9c. COUNTY OF DEATH: Prince George's

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Clinton	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 6815 Groveton Drive		10f. ZIP CODE: 20735	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [XX] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: 1950-1971	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Caucasian

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): N/A	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Supervisor/Voucher Examiner	16b. KIND OF BUSINESS/INDUSTRY: Dept. of Air Force	
17. FATHER'S NAME (First, Middle, Last): Homer Cross Rice		18. MOTHER'S NAME (First, Middle, Maiden Surname): Zerna Belinda Jordan	
19a. INFORMANT'S NAME (Type/Print): Mildred H. Rice		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6815 Groveton Drive Clinton, Md 20735	
20a. METHOD OF DISPOSITION: [XX] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Resurrection Cemetery	June 20, 1995	20c. LOCATION — City or Town, State: Clinton, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]	22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, Md 20735		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceuaed the death. Do not antar the mode of dying, auch as cardiac or respiratory arrest, ahock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. cranitis
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. metastatic lung cancer
DUE TO (OR AS A CONSEQUENCE OF):
c. renal failure
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: [X] 1 Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

26a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY M	26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	26d. DESCRIBE HOW INJURY OCCURED
26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D17601	29d. DATE SIGNED (Month, Day, Year): ▶ 6/19/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): D.J. HAIDAR MD 8926 WOODYARD RD, CLINTON, MD 20735

31. DATE FILED (Month, Day, Year): JUN 20 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DHMH-16 Rev 1/89

95 20325

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)		3. TIME OF DEATH
Douglas	Stancil		June	6 1995	6:00 P.M
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (If yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year) / 8. BIRTHPLACE (State or Foreign Country)
579-86-1095	1 [X] M 2 [ ] F	33 YRS.			Mar. 22 1962 Wash. D.C.

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Washingon Adventist Hospital	Takoma Park	Montgomery

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MD	Prince Georges	Hyattsville	1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
2504 Queens Chapel Rd. #304	20782	USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12): 12th	College (1-4 or 5+):	Dietary Aide	Guest Services

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Lorenzo Stancil	Ruth Peterson

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Delores A. Stancil	2504 Queens Chapel Rd.304 Hyattsville, Md. 20782

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
	Ft. Lincoln Cemetery	6-12	Brentwood, MD.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
J R Marshall	Marshall's Funeral Home 4217 9th St. N.W. Washington, D.C. 20011

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Tuberculosis Diffuse Pneumonia	6 wks
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Sepsis	6 wks
DUE TO (OR AS A CONSEQUENCE OF):		
	c. Acquired Immuno Deficiency Syndrome	
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Seizure Disorder

Anemia

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
	D19971	▶ 6-6-95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	
K. Sudhakar 7610 Carroll Ave. #230 Takoma Park, MD. 20912	
31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 14 1995	Julia Davidson-Randall

OHMH-18 Rev 1/89

(4)

95 20326

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Joseph Stasko Sr.		2. DATE OF DEATH: MONTH May DAY 27, YEAR 1995	3. TIME OF DEATH: 8:25P M
4. SOCIAL SECURITY NUMBER: 074-24-1230	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 65 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 8/21/1995
8. BIRTHPLACE (State or Foreign Country): New York			
9a. FACILITY NAME (If not institution, give street and number): 801 East Tantallon Drive	9b. CITY, TOWN OR LOCATION OF DEATH: Ft. Washington	9c. COUNTY OF DEATH: Prince Georges	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince Georges	10c. CITY, TOWN OR LOCATION: Ft. Washington	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 801 East Tantallon Drive	10f. ZIP CODE: 20744	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 5+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Elect. Engineer	16b. KIND OF BUSINESS/INDUSTRY: U.S. Government
17. FATHER'S NAME (First, Middle, Last): John Stasko		18. MOTHER'S NAME (First, Middle, Maiden Surname): Pelajhia Bodnar	
19a. INFORMANT'S NAME (Type/Print): Eugenia Stasko	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 801 East Tantallon Dr. Ft. Wash,MD.20744		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Georgetown Med. Sch. DATE 5/27/95	20c. LOCATION — City or Town, State: Washington, DC.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: Austin Royster Funeral Home 3605 14th Street N.W.,Wash, DC.20010		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Carcinoma of the duodenum	34mo
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Henry A. Pitt, M.D.	29c. LICENSE NUMBER: D21906	29d. DATE SIGNED (Month, Day, Year): ▶ June 6,1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Henry A. Pitt 688 Johns Hopkins Hospital,Baltimore,MD.21287		
31. DATE FILED (Month, Day, Year): JUN 14 1995	32. REGISTRAR'S SIGNATURE: [signature]	

(10)

DHMH-16 Rev 1/89

95 20327

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): David Allen Sampson, Sr.			2. DATE OF DEATH (Month, Day, Year): June 12, 1995	3. TIME OF DEATH: 9:50 a M
4. SOCIAL SECURITY NUMBER: 578-42-5378	5. SEX: 1 ☒ M 2 ☐ F	8. AGE (In yrs. last birthday): 62 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Oct. 24, 1932	8. BIRTHPLACE (State or Foreign Country): Washington, DC
9a. FACILITY NAME (If not institution, give street and number): 5929 89th Avenue		9b. CITY, TOWN OR LOCATION OF DEATH: New Carrollton		9c. COUNTY OF DEATH: Prince George's
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: New Carrollton		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 5929 89th Avenue		10f. ZIP CODE: 20784		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: Korea	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Elevator Mechanic	16b. KIND OF BUSINESS/INDUSTRY: U.S. Government		
17. FATHER'S NAME (First, Middle, Last): James Russell Sampson		18. MOTHER'S NAME (First, Middle, Maiden Surname): Dorothy Eileen Sampson		
19a. INFORMANT'S NAME (Type/Print): Betty M. Sampson	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5929 89th Avenue, New Carrollton, Maryland 20784			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Fort Lincoln Cemetery DATE: 6/15/95	20c. LOCATION — City or Town, State: Brentwood, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ W.B. Gasch	22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CANCINOMA of LARYNX	3 yr.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Roger Ingham	D05891	▶ 6-13-95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Roger Ingham, M.D. 6510 Kenilworth Avenue, Suite 2400, Riverdale, MD 20710

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 13 1995	Julia Davidson-Kendall

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DHMH-16 Rev 1/89

95 20328

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MILDRED SMITH		2. DATE OF DEATH (Month, Day, Year): JUNE 7 1995	3. TIME OF DEATH: 6:30A M
4. SOCIAL SECURITY NUMBER: 240-68-3425	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 52 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): JULY 3, 1942
8. BIRTHPLACE (State or Foreign Country): WILSON, NORTH CAROLINA			
9a. FACILITY NAME (If not institution, give street and number): PRINCE GEORGE'S HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH: CHEVERLY	9c. COUNTY OF DEATH: PRINCE GEORGE'S	

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: PRINCE GEORGE'S	10c. CITY, TOWN OR LOCATION: BLADENSBURG	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3801 KENILWORTH AVENUE #113E		10f. ZIP CODE: 20710	10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12):	College (1-4 or 5 +): 5+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SCHOOL TEACHER	16b. KIND OF BUSINESS/INDUSTRY: GOVERNMENT
17. FATHER'S NAME (First, Middle, Last): JAMES HENRY FORD, SR.		18. MOTHER'S NAME (First, Middle, Maiden Surname): LILLIE WARD	
19a. INFORMANT'S NAME (Type/Print): REV. BOYCE L. SMITH/HUSBAND		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3801 KENILWORTH AVE. #113E BLADENSBURG, MD 20710	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): REST HAVEN	DATE: 6/11/95	20c. LOCATION — City or Town, State: WILSON, N.C.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Kimberly Buscoe-Tonic		22. NAME AND ADDRESS OF FACILITY: J.B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MD 20785	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Aspiration Pneumonia.	10-12 Hrs.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Multiple Sclerosis

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D	29c. LICENSE NUMBER: 042580.	29d. DATE SIGNED (Month, Day, Year): ▶ 6/7/95.
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 6501 Landover Road Cheverly MD 20785.		
31. DATE FILED (Month, Day, Year): JUN 13 1995	32. REGISTRAR'S SIGNATURE: [signature]	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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95 20329

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): FLORENCE HILDT STRAWBRIDGE			2. DATE OF DEATH (Month, Day, Year): June 17, 1995	3. TIME OF DEATH: 10:50 A M
4. SOCIAL SECURITY NUMBER: 213-74-3444	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 97 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): July 12,1897	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Bel Forest Nursing & Rehab. Center		9b. CITY, TOWN OR LOCATION OF DEATH: Forest Hill	9c. COUNTY OF DEATH: Harford	
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Bel Air	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER: 925 Rock Spring Rd.		10f. ZIP CODE: 21014	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Home		
17. FATHER'S NAME (First, Middle, Last): Walter Finney Bailey		18. MOTHER'S NAME (First, Middle, Maiden Surname): Laura Rebecca Anderson		
19a. INFORMANT'S NAME (Type/Print): Ruth H. Smithson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 925 Rock Spring Rd., Bel Air, Md. 21014		
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Centre U. M. Cemetery	DATE: 6-21-95	20c. LOCATION — City or Town, State: Forest Hill, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Howard K. McComas		22. NAME AND ADDRESS OF FACILITY: Howard K. McComas III Funeral Home, P.A. 50 W. Broadway St., Bel Air, Md. 21014		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Alzheimers dementia	>5 yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: David S. D	29c. LICENSE NUMBER: D32255	29d. DATE SIGNED (Month, Day, Year): ▶ 6/21/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DAVID S. DUNN 1131 Bel Air Rd		
31. DATE FILED (Month, Day, Year): JUN 21 1995	32. REGISTRAR'S SIGNATURE: John Hutchison Randall	

DHMH-16 Rev 1/89

95 20330

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN R. SMITH			2. DATE OF DEATH (Month, Day, Year): JUNE 12, 1995	3. TIME OF DEATH: 00:20 AM
4. SOCIAL SECURITY NUMBER: 214 28 4434	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.	7. DATE OF BIRTH (Month, Day, Year): 01/30/29	8. BIRTHPLACE (State or Foreign Country): WashingtonDC
9a. FACILITY NAME (If not institution, give street and number): SOUTHERN MARYLAND HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: CLINTON		9c. COUNTY OF DEATH: PRINCE GEORGES

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Brandywine	10d. INSIDE CITY LIMITS? XX 1 YES 2 NO
10e. STREET AND NUMBER: 13628 Tower Road		10f. ZIP CODE: 20613	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [XX] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [XX] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Custodian	16b. KIND OF BUSINESS/INDUSTRY: US Postal Service	
17. FATHER'S NAME (First, Middle, Last): John R. Smith, Sr		18. MOTHER'S NAME (First, Middle, Maiden Surname): Harriet Woods	
19a. INFORMANT'S NAME (Type/Print): DeLois Smith	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13628 Tower Road Brandywine, MD 20613		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Gibbons UMC Cemetery DATE: 6/15/95	20c. LOCATION — City or Town, State: Brandywine, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Lloyd M. Estep	22. NAME AND ADDRESS OF FACILITY: Adams Funeral Home, PA Aquasco Road, Aquasco, MD 20608		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Sepsis	96 hrs
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Arteriosclerotic Cardiovascular Disease	Yes
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Cerebral Vascular Accident	Yes
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Thomas L Fredson MD	29c. LICENSE NUMBER: D01923	29d. DATE SIGNED (Month, Day, Year): 12 June 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): T.L. Fredson M.D. Brandywine, MD 20613		
31. DATE FILED (Month, Day, Year): JUN 21 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 20331

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Francis Leroy Sharrer			2. DATE OF DEATH (Month, Day, Year): June 18, 1995	3. TIME OF DEATH: 9:00 AM
4. SOCIAL SECURITY NUMBER: 216-07-2893A	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 77 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): Feb. 6, 1918	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick		9c. COUNTY OF DEATH: Frederick
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Ladiesburg		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 12509 A Woodsboro Pike		10f. ZIP CODE: 21759		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 years; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Carpenter		16b. KIND OF BUSINESS/INDUSTRY: None
17. FATHER'S NAME (First, Middle, Last): David Leroy Sharrer		18. MOTHER'S NAME (First, Middle, Maiden Surname): Nova Beall		
19a. INFORMANT'S NAME (Type/Print): Ethel V. Sharrer		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12509 A Woodsboro Pike Ladiesburg, MD 21759		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Tabor Cemetery	DATE: 6/21	20c. LOCATION — City or Town, State: Rocky Ridge, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert E. Dailey Jr.		22. NAME AND ADDRESS OF FACILITY: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 East Main Street Thurmont, MD 21788		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. SEPSIS	2-4wks
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF): Ischemic Gangrene	
	c. DUE TO (OR AS A CONSEQUENCE OF): Diabetes mellitus	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: END STAGE RENAL Disease

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [✓] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [✓] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [✓]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
M.D.	D29555	▶ 6/20/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARK P. RUBIN MD 56 Thomas Johnson Dr FREDERICK MD 21702

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 21 1995	Julia Hawkins-Randall

DHMH-16 Rev 1/89

95 20332

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEOENT'S NAME (First, Middle, Last): GEORGE WALLACE STEWART		2. DATE OF DEATH (Month, Day, Year): June 17 1995	3. TIME OF DEATH: 7:26 AM
4. SOCIAL SECURITY NUMBER: 214-07-7071	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 78 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): July 3 1916
8. BIRTHPLACE (State or Foreign Country): Maryland			
9a. FACILITY NAME (If not institution, give street and number): Dorchester General Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Cambridge	9c. COUNTY OF DEATH: Dorchester	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Dorchester	10c. CITY, TOWN OR LOCATION: Cambridge	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 2250 Key Wallace Drive		10f. ZIP CODE: 21613	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: World War II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Warden / Agent	16b. KIND OF BUSINESS/INDUSTRY: U.S. Wildlife Refuge	
17. FATHER'S NAME (First, Middle, Last): George Thomas Stewart		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ruth Wallace	
19a. INFORMANT'S NAME (Type/Print): Miss Deboarh S. Stewart	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2250 Key Wallace Drive, Cambridge MD 21613		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): E. New Market Cemetery DATE: 6/20	20c. LOCATION — City or Town, State: E. New Market Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Kenneth R Thomas Jr.	22. NAME AND ADDRESS OF FACILITY: Thomas Funeral Home 700 Locust St. Cambridge MD 21613		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on esch line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition resulting in death) →	a. Cerebroversular Accident	2 hours
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if sny, leading to immediate csuse. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.: Acute and chronic renal failure

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Edmund J MacLaughlin	29c. LICENSE NUMBER: D-28209	29d. DATE SIGNED (Month, Day, Year): June 17, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Edmund J. MacLaughlin 4 Aurora St. Cambridge, Md 21613		
31. DATE FILED (Month, Day, Year): JUN 2 0 1995	32. REGISTRAR'S SIGNATURE: Julia Thurlow Randall	

OHMH-16 Rev 1/89

95 20333

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Marcia Dyer Schuster			2. DATE OF DEATH (Month, Day, Year): June 8 1995	3. TIME OF DEATH: 1:30P M
4. SOCIAL SECURITY NUMBER: 579-42-6571	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 64 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): Dec 6 1930	8. BIRTHPLACE (State or Foreign Country): Washington, D.C.
9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis	9c. COUNTY OF DEATH: Anne Arundel	
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Annapolis	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO	
10e. STREET AND NUMBER: 3410 Newport Avenue		10f. ZIP CODE: 21403	10g. CITIZEN OF WHAT COUNTRY?: United States	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+): 1		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Accountant	16b. KIND OF BUSINESS/INDUSTRY: Accounting	
17. FATHER'S NAME (First, Middle, Last): Marion Dyer		18. MOTHER'S NAME (First, Middle, Maiden Surname): UNAVAILABLE		
19a. INFORMANT'S NAME (Type/Print): Robert Bennington		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4058 Willow Run Dr. Dayton, Ohio 45430		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Ft. Lincoln Crematory 6/9/95 DATE	20c. LOCATION — City or Town, State: Brentwood, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]		22. NAME AND ADDRESS OF FACILITY: John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final diseese or condition resulting in death) →
a. sudden cardiac death
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. ischemic cardiomyopathy
DUE TO (OR AS A CONSEQUENCE OF):
c. CAD
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I.
severe COPD, resp failure

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☒ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. LICENSE NUMBER: D41816
29d. DATE SIGNED (Month, Day, Year): ▶ June 9 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles W. Phelps, M.D. 180 Admiral Cochrane Drive Annapolis, MD 21401 (573-1047)

31. DATE FILED (Month, Day, Year): JUN 20 1995
32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

AMENDED 6-20-95
#25/att

95 20334

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Loretta Theresa Sandvik			2. DATE OF DEATH (Month, Day, Year): June 18 1995	3. TIME OF DEATH: 2:20A M
4. SOCIAL SECURITY NUMBER: 212-05-0150	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 86 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): May 19 1909	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Meridian Health Care Ctr. Spa Creek		9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis		9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Edgewater	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 144 Mayo Road		10f. ZIP CODE: 21037	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Proprietor	16b. KIND OF BUSINESS/INDUSTRY: Restaurant	
17. FATHER'S NAME (First, Middle, Last): Henry Wolff		18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine Hickman	
19a. INFORMANT'S NAME (Type/Print): Donald R. Davis, Sr.	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 613 Oak Lane Severna Park, MD 21146		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Ft. Lincoln Crematory DATE 6/19/96	20c. LOCATION — City or Town, State: Brentwood, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Steven Hutchison	22. NAME AND ADDRESS OF FACILITY: John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Coronary atherosclerotic disease	many years
	DUE TO (OR AS A CONSEQUENCE OF): —	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF): —	
	c.	
	OUE TO (OR AS A CONSEQUENCE OF): —	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. —

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: ☒ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Charles W. Kinzer	29c. LICENSE NUMBER: D05928	29d. DATE SIGNED (Month, Day, Year): ▶ June 19 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles Kinzer, M.D. 1833A Forest Dr. Annapolis, MD 21401

31. DATE FILED (Month, Day, Year): JUN 20 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DHMH-16 Rev 1/89

95 20335

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GEORGE T. SULLIVAN				2. DATE OF DEATH (Month, Day, Year): JUNE 21, 1995	3. TIME OF DEATH: 9:05 A.M. M
4. SOCIAL SECURITY NUMBER: 137 26 1658	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 60 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Oct. 15, 1934	8. BIRTHPLACE (State or Foreign Country): New Jersey
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Bowie	10d. INSIDE CITY LIMITS? ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 4025 William Lane		10f. ZIP CODE: 20715	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 5	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Agent	16b. KIND OF BUSINESS/INDUSTRY: FBI
17. FATHER'S NAME (First, Middle, Last): Daniel Joseph Sullivan		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Alma O'Neill	
19a. INFORMANT'S NAME (Type/Print): Bernice Sue Sullivan		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4025 William Lane Bowie Maryland 20715	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Sacred Heart Church Cemetery	DATE	20c. LOCATION — City or Town, State: 6/24/95 Bowie Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert E. Evans Pres		22. NAME AND ADDRESS OF FACILITY: Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Sepsis	1 week
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF): Allogeneic Bone Marrow Transplantation	41 days
	c. DUE TO (OR AS A CONSEQUENCE OF): Secondary M7 Acute Myelogenous Leukemia	9 months
	d. DUE TO (OR AS A CONSEQUENCE OF): Alkylating therapy for Autoimmune Multifocal Motor Neuropathy	10 years

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒	24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURED
			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Stephen B. Gruber, M.D.	29c. LICENSE NUMBER: M5760	29d. DATE SIGNED (Month, Day, Year): ▶ June 21, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Stephen B. Gruber MD Johns Hopkins Oncology Center 600 N Wolfe St Baltimore, MD		
31. DATE FILED (Month, Day, Year): JUN 28 1995	32. REGISTRAR'S SIGNATURE: Julia Dudley Rudolph	

DHMH-16 Rev 1/89

95 20336

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6 1/5

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Otis Darnell Thorpe			2. DATE OF DEATH (Month, Day, Year): June 11, 1995	3. TIME OF DEATH: 5:30 AM
4. SOCIAL SECURITY NUMBER: 242-96-6355	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 38 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): FEB 1, 1957	8. BIRTHPLACE (State or Foreign Country): North Carolina
9a. FACILITY NAME (If not institution, give street and number): Washington Adventist Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: TAkoma		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince Georges	10c. CITY, TOWN OR LOCATION: Capitol Heights	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 821 Carrington Avenue		10f. ZIP CODE: 20743	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Dry Wall Finisher	16b. KIND OF BUSINESS/INDUSTRY: Private Construction	
17. FATHER'S NAME (First, Middle, Last): Percy Thorpe		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mildred Dunn	
19a. INFORMANT'S NAME (Type/Print): Dorothy Avent		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 832 Carrington Avenue, Seat Pleasant, Md 20743	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery	DATE: 6/17	20c. LOCATION — City or Town, State: Brentwood, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Alex S Pope Jr M859		22. NAME AND ADDRESS OF FACILITY: ALEXANDER S. POPE FUNERAL HOMES 5538 Marlboro Pike, Forestville, Md 20747	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	acquired immune deficiency syndrome	unkn
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: Pneumocystis carinii pneumonia. wasting syndrome

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [?]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Lewis Dennis MD	29c. LICENSE NUMBER: D01499	29d. DATE SIGNED (Month, Day, Year): JUN 11 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. LEWIS DENNIS Wash Adv Hosp TAKoma Pa. Md		
31. DATE FILED (Month, Day, Year): JUN 16 1995	32. REGISTRAR'S SIGNATURE: Julia Dawkins Randall	

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DHMH-16 Rev 1/89

95 20337

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RUTH E THOMPSON			2. DATE OF DEATH (Month, Day, Year): June 11, 1995	3. TIME OF DEATH: 8:10 AM
4. SOCIAL SECURITY NUMBER: 579-66-5123	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 40 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 12-10-54
8. BIRTHPLACE (State or Foreign Country): Washington D.C				
9a. FACILITY NAME (If not institution, give street and number): 3812 Alta Vista Drive		9b. CITY, TOWN OR LOCATION OF DEATH: Mitchellville,		9c. COUNTY OF DEATH: Prince Georges
RESIDENCE OF DECEDENT				
10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION: Washington D.C.		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1605 S Street, NW		10f. ZIP CODE: 20009		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): . Technician		16b. KIND OF BUSINESS/INDUSTRY: Xerox Corp.
17. FATHER'S NAME (First, Middle, Last): Edward Thompson		18. MOTHER'S NAME (First, Middle, Maiden Surname): Cornelia Johnson		
19a. INFORMANT'S NAME (Type/Print): Lillian Coplin		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11401 Glissade Dr., Clinton, MD 20735		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Harmony Mem. Park	DATE: 6-16	20c. LOCATION — City or Town, State: Landover, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: Strickland Funeral Svc. 9507 Silver Fox Turn, Clinton, MD		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ADS — DUE TO (OR AS A CONSEQUENCE OF): — 4 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. — DUE TO (OR AS A CONSEQUENCE OF):

c. — DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D19431	29d. DATE SIGNED (Month, Day, Year): 6/15/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Frank M. Regan M.D. 6188 Oxon Hill Rd #610 Oxon Hill Md 20745		
31. DATE FILED (Month, Day, Year): JUN 16 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

(3)

DHMH-16 Rev 1/89

95 20338

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Carrie Bell Tibbs
2. DATE OF DEATH (Month, Day, Year): June 1 1995
3. TIME OF DEATH: 12:50 p M
4. SOCIAL SECURITY NUMBER: 425-36-6709
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 77 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 4-21-18
8. BIRTHPLACE (State or Foreign Country): Mississippi
9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring
9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Montgomery
10c. CITY, TOWN OR LOCATION: Silver Spring
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 13305 Octagon Lane
10f. ZIP CODE: 20904
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4 or 5+): 4
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Hospital Bakery Supv.
16b. KIND OF BUSINESS/INDUSTRY: Hospital
17. FATHER'S NAME (First, Middle, Last): Charlie Clemons
18. MOTHER'S NAME (First, Middle, Maiden Surname): Carrie Bell McDonald
19a. INFORMANT'S NAME (Type/Print): Wanzer Tibbs
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13305 Octagon Lane, Silver Spring MD 20904
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Culpeper National Cemetery — DATE: 6/7/95
20c. LOCATION — City or Town, State: Culpeper, VA.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: W.C. Thompson F.H. 503-7 N. Main Street Culpeper, Va. 22701

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complicetione thet ceused the death. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heert feilure. Llet only one ceuse on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	geraftic Supra	2 days
DUE TO (OR AS A CONSEQUENCE OF): b.	uremia - leu	1-2 wks
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	chron congestive heart fail	
d.	Diabetes	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D.
29c. LICENSE NUMBER: M.D. 1232
29d. DATE SIGNED (Month, Day, Year): 6/1/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Gilbert B. Cushner 11161 New Hampshire Ave SS MD 20904

31. DATE FILED (Month, Day, Year): JUN 13 1995
32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DHMH-16 Rev 1/89

(6)

Amended # 19A, P.G. D.C. 6/13/95

95 20339

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN THOMAS			2. DATE OF DEATH Month: JUN Day: 8 Year: 95	3. TIME OF DEATH: 0930 A M
4. SOCIAL SECURITY NUMBER: 577-64-6705	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 48 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year): May 20, 1947	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Deaton Specialty Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH: N/A
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY: N/A	10c. CITY, TOWN OR LOCATION: Baltimore		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 611 South Charles Street		10f. ZIP CODE:		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 8th College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer		16b. KIND OF BUSINESS/INDUSTRY: Private
17. FATHER'S NAME (First, Middle, Last): John Thomas, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Yolanda Soule?/Lili Wells		
19a. INFORMANT'S NAME (Type/Print): Yolanda Yolana Soule		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1302 Chapel Oaks Dr. Capitol Heights, MD 20743		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Harmony Memorial Park DATE: Jun16	20c. LOCATION — City or Town, State: Landover, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Juwana L. Braton		22. NAME AND ADDRESS OF FACILITY: J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. SEPSIS 2° WOUND INFECTION	2 WKS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: PERSISTENT VEGETATIVE STATE

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [X]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Brian C. Wallace MD	D31136	▶ JUNE 9, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BRIAN C. WALLACE, MD, 611 S. CHARLES ST., BALTIMORE, MD 21230

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 13 1995	Gwendolyn Randall

3

DHMH-16 Rev 1/89

95 20340

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Leon Edward Thomas			2. DATE OF DEATH (Month, Day, Year): June 15 1995	3. TIME OF DEATH: 6:10 AM
4. SOCIAL SECURITY NUMBER: 284-26-2918	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 73 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.	7. DATE OF BIRTH (Month, Day, Year): Sept. 17, 1921	8. BIRTHPLACE (State or Foreign Country): West Virginia
9a. FACILITY NAME (If not institution, give street and number): Residence: 631 Broad St., Apt. 3		9b. CITY, TOWN OR LOCATION OF DEATH: Perryville	9c. COUNTY OF DEATH: Cecil	
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Cecil	10c. CITY, TOWN OR LOCATION: Perryville	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO	
10e. STREET AND NUMBER: 631 Broad Street, Apt. 3		10f. ZIP CODE: 21903	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WW II & Korean Conflict	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [XX] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): Twelve Years — College (1-4 or 5+): --------		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Orthopedic Technician	16b. KIND OF BUSINESS/INDUSTRY: Orthopedic Associates, P.A. Havre de Grace, Maryland	
17. FATHER'S NAME (First, Middle, Last): John Edward Thomas			18. MOTHER'S NAME (First, Middle, Maiden Surname): Emma Belcher	
19a. INFORMANT'S NAME (Type/Print): Jean Phyllis Thomas		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 631 Broad St., Apt. 3, Perryville, Maryland 21903		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Arlington National Cemetery — DATE: 6/20/95	20c. LOCATION — City or Town, State: Arlington, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Thomas H. Patterson, Sr.		22. NAME AND ADDRESS OF FACILITY: Lee A. Patterson & Son Funeral Home Perryville, Maryland 21903		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. NON SMALL CELL LUNG CANCER	1 YEAR
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [XX] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [X] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
MD	D38409	▶ 6/15/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 4940 Eastern Ave, Baltimore, Md 21224

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 16 1995	Julie Davidson-Randall

DHMH-18 Rev 1/89

11
+1 VA

95 20341

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Drucilla M. Tull			2. DATE OF DEATH (Month, Day, Year): June 16 1995	3. TIME OF DEATH: 4:53 p M
4. SOCIAL SECURITY NUMBER: 218-09-5713	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 82 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 2/08/13	8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): Atlantic General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Berlin		9c. COUNTY OF DEATH: Worcester
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY: Worcester	10c. CITY, TOWN OR LOCATION: Snow Hill		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 111 N. Collins		10f. ZIP CODE: 21863		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Seamstress		16b. KIND OF BUSINESS/INDUSTRY: Sewing Garment Co.
17. FATHER'S NAME (First, Middle, Last): Alonzo Matthews		18. MOTHER'S NAME (First, Middle, Maiden Surname): Flossie Matthews		
19a. INFORMANT'S NAME (Type/Print): Richard F. Tull		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 114 Oaklee Drive, Fruitland, Md. 21826		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Nelson Cemetery	DATE: 6/19	20c. LOCATION — City or Town, State: Pocomoke, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Patricia L. Denny		22. NAME AND ADDRESS OF FACILITY: Dennis Funeral Home, Snow HIll, Md. 21863		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Acute Myocardial infarct.	1 hour
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b.	Coronary Artery Disease	2 years
DUE TO (OR AS A CONSEQUENCE OF): c.	None	
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Fanconi Disease
Severe Degenerative Arthritis

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
	D02026	June 16 95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Federico G. Arthes, MD 1622A Ocean Pines Berlin, MD. 21811 410-641-6363

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 20 1995	Julia Davidson-Rudolph

2

DHMH-16 Rev 1/89

95 20342

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ibrahim S. Tarawally ~~Traore~~ sd			2. DATE OF DEATH (Month, Day, Year): 6 / 16 / 95	3. TIME OF DEATH: 6:45 AM
4. SOCIAL SECURITY NUMBER: N/A	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS 05 / MIN. 02	7. DATE OF BIRTH (Month, Day, Year): June 16, 1995	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Washington Adventist Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Takoma Park		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Howard	10c. CITY, TOWN OR LOCATION: Savage	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 8723 Baltimore Street		10f. ZIP CODE: 20763	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4 or 5+): N/A	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): N/A	16b. KIND OF BUSINESS/INDUSTRY: N/A	
17. FATHER'S NAME (First, Middle, Last): Ibrahim Tarawally		18. MOTHER'S NAME (First, Middle, Maiden Surname): Adama Traore	
19a. INFORMANT'S NAME (Type/Print): Suseela Drumheller	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7600 Carroll Avenue; Takoma Park, MD 20912		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Washington Adventist Hosp.	DATE: '95	20c. LOCATION — City or Town, State: Takoma Park, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Suseela Drumheller/Hospital Representative	22. NAME AND ADDRESS OF FACILITY: 7600 Carroll Avenue; Takoma Park, MD 20912		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. asphyxia	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. extreme prematurity of 22-23 wk gestation	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Michael Darden MD - physician	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶ 6/16/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Michael Darden, M.D. ; 7600 Carroll Ave., Takoma Park, MD 20912

31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: Julia Strickland Randall

OHMH-16 Rev 1/89

95-3506-021
B.K.S

ITEMS: 23 PART I, 27, PER MEO FILM G-726 8/7/95 t.t

95 20343

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): TYRIS DEEVINE TOMS				2. DATE OF DEATH (Month, Day, Year): JUNE 14, 1995	3. TIME OF DEATH: 1007 A M
4. SOCIAL SECURITY NUMBER: 218-43-4012	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): YRS.	IF UNDER 1 YEAR: MONTHS 3 / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): March 15, 1995	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): FREDERICK MEMORIAL HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: FREDERICK		9c. COUNTY OF DEATH: FREDERICK	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Frederick	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 525 Ellrose Court		10f. ZIP CODE: 21702	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): Alfred Boone Fisher, Jr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Donna Dion Toms	
19a. INFORMANT'S NAME (Type/Print): Renee Joyner	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 525 Ellrose Court, Frederick, MD 21702		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place): Resthaven Memorial Gardens 6/17/1995	20c. LOCATION — City or Town, State: Frederick, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ryan M. Berger	22. NAME AND ADDRESS OF FACILITY: Stauffer Funeral Home, 1621 Opossumtown Pike, Frederick MD 21702		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. SUDDEN INFANT DEATH SYNDROME	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [✓] YES 2 [ ] NO	1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient XX ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [XX] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [✓] Pending investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Wayne Bell MD	29c. LICENSE NUMBER: O.C.M.E	29d. DATE SIGNED (Month, Day, Year): ▶ JUNE 15, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARYANN B. KOPECNY 111 Penn Street, Baltimore, Maryland 21201

31. DATE FILED (Month, Day, Year): JUN 19 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 20344

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Lillie Marie TODD			2. DATE OF DEATH (Month, Day, Year): June 16, 1995	3. TIME OF DEATH: 8:31 P M
4. SOCIAL SECURITY NUMBER: 215-01-7353	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Feb. 8 1917	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Rossville		9c. COUNTY OF DEATH: Baltimore County

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Rossville	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 6600 Ridge Rd.		10f. ZIP CODE: 21237	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): homemaker	16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): Alfred Reynolds		18. MOTHER'S NAME (First, Middle, Maiden Surname): Lorena Jones	
19a. INFORMANT'S NAME (Type/Print): Mrs. Kathleen Kaniecki	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9407 Dawnville Rd., Baltimore MD 21236		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Dorchester Memorial Park 6/20	DATE	20c. LOCATION — City or Town, State: Cambridge Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Kenneth R Thomas Jr.	22. NAME AND ADDRESS OF FACILITY: Thomas Funeral Home 700 Locust St. Cambridge MD 21613		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Myocardial Infarction	1 Hr.
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Arteriosclerotic Cardiovascular Disease	Ten years
DUE TO (OR AS A CONSEQUENCE OF):		
	c.	
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Atrial Fibrillation

Old Cerebrovascular Accident with right hemiplegia

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☑

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D17728	29d. DATE SIGNED (Month, Day, Year): ▶ 6-17-95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ba Yin Oung, MD 8022 Belair Rd. Baltimore Md. 21236

31. DATE FILED (Month, Day, Year): JUN 2 0 1995	32. REGISTRAR'S SIGNATURE: Julia Bowden-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 20345

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Charles Thomas Turner			2. DATE OF DEATH (Month, Day, Year): June 17, 1995	3. TIME OF DEATH: 8:00 P M
4. SOCIAL SECURITY NUMBER: 218-16-8736	5. SEX: 1 XX M 2 ☐ F	6. AGE (In yrs. last birthday): 75 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): Oct 13, 1919	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 510 Goldsborough Avenue		9b. CITY, TOWN OR LOCATION OF DEATH: Cambridge		9c. COUNTY OF DEATH: Dorchester

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Dorchester	10c. CITY, TOWN OR LOCATION: Cambridge	10d. INSIDE CITY LIMITS? XX 1 YES 2 ☐ NO
10e. STREET AND NUMBER: 510 Goldsborough Avenue		10f. ZIP CODE: 21613	10g. CITIZEN OF WHAT COUNTRY?: US

11. MARITAL STATUS: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Commercial Waterman	16b. KIND OF BUSINESS/INDUSTRY: Seafood	
17. FATHER'S NAME (First, Middle, Last): John Turner		18. MOTHER'S NAME (First, Middle, Maiden Surname): Susie Bramble	
19a. INFORMANT'S NAME (Type/Print): Florence S. Turner		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 510 Goldsborough Ave. Cambridge, Maryland 21613	
20a. METHOD OF DISPOSITION: 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Dorchester Memorial Park	DATE: 6/21	20c. LOCATION — City or Town, State: Cambridge, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]		22. NAME AND ADDRESS OF FACILITY: Thomas Funeral Home 700 Locust St. Cambridge, Maryland 21613	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Ischemic Heart Disease	4 hr
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF): Dilated Cardiomyopathy	2 yr
	c. DUE TO (OR AS A CONSEQUENCE OF): Ventricular Dysrhythmia	4 hr
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☑ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Judy C. Washington MD	29c. LICENSE NUMBER: 031108	29d. DATE SIGNED (Month, Day, Year) ▶ 6/19/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Judy C. Washington MD 408 Bayly Street Cambridge, MD 21613		
31. DATE FILED (Month, Day, Year): JUN 20 1995	32. REGISTRAR'S SIGNATURE: [signature]	

DHMH-16 Rev 1/89

6

95 20346

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Genevieve L. Truter			2. DATE OF DEATH: MONTH June 16, DAY 1995 YEAR	3. TIME OF DEATH: 9 30 A M
4. SOCIAL SECURITY NUMBER: 194-24-9022	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 66 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): July 31, 1928	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): 913 Ravenshead Hill		9b. CITY, TOWN OR LOCATION OF DEATH: Sherwood Forest		9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Sherwood Forest	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 913 Ravenshead Hill		10f. ZIP CODE: 21405	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher	16b. KIND OF BUSINESS/INDUSTRY: Education
17. FATHER'S NAME (First, Middle, Last): William L. Gates		18. MOTHER'S NAME (First, Middle, Maiden Surname): Genevieve Schrecongost	
19a. INFORMANT'S NAME (Type/Print): Edmund Truter		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 913 Ravenshead Hill, Sherwood Forest, MD 21405	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Lakemont Mem. Gardens DATE: 6/17	20c. LOCATION — City or Town, State: Davidsonville, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Steven H. Williams		22. NAME AND ADDRESS OF FACILITY: John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, 21401	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not anter tha mode of dying, such as cardiac or respiratory arreat, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Breast Cancer.	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Ascites

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	26a. DATE OF INJURY (Month, Day, Year) / 26b. TIME OF INJURY M / 26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	26d. DESCRIBE HOW INJURY OCCURED
	26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D 31650	29d. DATE SIGNED (Month, Day, Year): ▶ 6-16-95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOHN GUTHEIL 22 GREENE ST. BALTO, MD.		
31. DATE FILED (Month, Day, Year): JUN 20 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall	

DHMH-16 Rev 1/89

95 20347

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): VIVERT ALTAR WILLIS, JR.		2. DATE OF DEATH (Month, Day, Year): June 10 1995	3. TIME OF DEATH: 7:00p M
4. SOCIAL SECURITY NUMBER: 577-32-9655	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 66 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): July.4,1929
8. BIRTHPLACE (State or Foreign Country): Pennsylvania			
9a. FACILITY NAME (If not institution, give street and number): 2021 Brooks Dr. #t-23	9b. CITY, TOWN OR LOCATION OF DEATH: Forestville	9c. COUNTY OF DEATH: Prince George's	
RESIDENCE OF DECEDENT			
10a. STATE: MD	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Forestville	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2021 Brooks Drive	10f. ZIP CODE:	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12):	College (1-4 or 5+): 4yrs	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housing Coordinator	16b. KIND OF BUSINESS/INDUSTRY: Government
17. FATHER'S NAME (First, Middle, Last): Vivert A. Willis,Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary F. Thornton	
19a. INFORMANT'S NAME (Type/Print): Vivette Wallace		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3412 East 110th St. Cleveland,Oh.	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place): Harmony Memorial Park	DATE: June16	20c. LOCATION — City or Town, State: Landover,MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Duawana L. Braxton		22. NAME AND ADDRESS OF FACILITY: J.B. Jenkins Funeral Home 7474 Landover Rd. Landover,Md. 20785	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. hepatic failure	3mo.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. cirrhosis of liver	6mo.
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Martin D. Wolfson	29c. LICENSE NUMBER: D23743	29d. DATE SIGNED (Month, Day, Year): ▶ 6/12/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARTIN D. WOLFSON 7525 Greenway Ct Dr Greenbelt MD 20770		
31. DATE FILED (Month, Day, Year): JUN 13 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

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95 20348

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
Ernest	Charles	Woodhouse	June 11, 1995	3:15 A M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
577-22-2953	1 ☒ M 2 ☐ F	76 YRS.			Nov. 10, 1918	Washington, DC

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Washington Adventist Hospital	Takoma Park	Montgomery

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Prince George's	College Park	1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
5822 Swarthmore Drive	20740	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES?	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	1 ☐ YES 2 ☒ NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5 +)		
12		Machinist	U.S. Government

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Ernest T. Woodhouse	Anna Maria Hult

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ruth E. Woodhouse	5822 Swarthmore Drive, College Park, Maryland 20740

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Fort Lincoln Cemetery	6/15/95	Brentwood, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ W. B. Geiser	Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. BRONCHOPNEUMONIA	7 MONTHS
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): b. RIGHT PLEURAL MESOTHELIOMA	
	DUE TO (OR AS A CONSEQUENCE OF): c.	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☒ YES 2 ☐ NO	1 ☒ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	D22910	▶ JUNE 12TH 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
ASIF S. QADRI - 4700 BERWYN HOUSE RD, COLLEGE PK MD

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 13 1995	Julia Marvelon Randall

8

DHMH-16 Rev 1/89

95 20349

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JULIA WEDGE				2. DATE OF DEATH (Month, Day, Year): JUNE 09 1995	3. TIME OF DEATH: 8:25 pM
4. SOCIAL SECURITY NUMBER: 579-22-2655	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 101 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Aug. 10 1893	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Golden Oaks Nursing Home			9b. CITY, TOWN OR LOCATION OF DEATH: Laurel		9c. COUNTY OF DEATH: Prince George's

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Seat Pleasant	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 609 Birchleaf Avenue		10f. ZIP CODE: 20743	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0 / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Private	
17. FATHER'S NAME (First, Middle, Last): UNKNOWN		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARGARET WATERS	
19a. INFORMANT'S NAME (Type/Print): Thomas E. Wedge		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 609 Birchleaf Ave. Seat Pleasant,Md. 20743	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other piece): Moses Cemetery	DATE: 95 Jun 16	20c. LOCATION — City or Town, State: Lothian,MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Shawana L. Brayton		22. NAME AND ADDRESS OF FACILITY: J.B. Jenkins Funeral Home 7474 Landover Rd. Landover,Md. 20785	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arreat, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition resulting in death) →	a. Pneumonia	1 week
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Cardiac Arrhythmia	7 years
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Organic Brain Syndrome

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D 25430	29d. DATE SIGNED (Month, Day, Year): ▶ June 10,1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John Margous 14333 Laurel Bowie Rd. 307 Laurel, MD. 20708		
31. DATE FILED (Month, Day, Year): JUN 15 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

95 20350

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Arthur L. Williams			2. DATE OF DEATH (Month, Day, Year): June 12, 1995	3. TIME OF DEATH: 6:15 A. M
4. SOCIAL SECURITY NUMBER: 579-03-3986	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 8/1/13	8. BIRTHPLACE (State or Foreign Country): Georgia
9a. FACILITY NAME (If not institution, give street and number): Carroll Manor Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: Hyattsville		9c. COUNTY OF DEATH: Prince George's

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: P.G.	10c. CITY, TOWN OR LOCATION: Seat Pleasant	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 611 62nd Avenue		10f. ZIP CODE: 20743	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Presser	16b. KIND OF BUSINESS/INDUSTRY: Cleaners	
17. FATHER'S NAME (First, Middle, Last): Unknown		18. MOTHER'S NAME (First, Middle, Maiden Surname): Lula White	
19a. INFORMANT'S NAME (Type/Print): Augustine L. Edmunds	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1502 Boundary Ave.# 201, Cap. Hgts., Md. 20743		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland Nat'l. Mem. Park DATE: 6/16/95	20c. LOCATION — City or Town, State: Laurel, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Larry N. Pratt	22. NAME AND ADDRESS OF FACILITY: H.S. Washington & Sons, Inc. 4925 Burroughs Ave., N.E.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Acute Left Ventricular Failure	1 hour
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. DUE TO (OR AS A CONSEQUENCE OF):	Pneumonia Left Lung	5 days
c. DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: James Foster M.D.	29c. LICENSE NUMBER: D04179	29d. DATE SIGNED (Month, Day, Year): ▶ June 14, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James Foster, M.D. 5530 Wisconsin Ave.# 925, Chevy Chase, Md. 20815			
31. DATE FILED (Month, Day, Year): JUN 15 1995	32. REGISTRAR'S SIGNATURE: Julia Strickland Rodell		

(3)

OHMH-16 Rev 1/89

95 20351

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Parthenia B. Williams			2. DATE OF DEATH (Month, Day, Year): June 11, 1995	3. TIME OF DEATH: 2:30 A. M
4. SOCIAL SECURITY NUMBER: 578-20-3151	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 74 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.	7. DATE OF BIRTH (Month, Day, Year): 1/9/21	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Sylvan Manor Health Care Center		9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Glenn Dale	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 5214 Glenn Dale Rd.		10f. ZIP CODE: 20769	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housekeeper	16b. KIND OF BUSINESS/INDUSTRY: Glenn Dale Hospital	
17. FATHER'S NAME (First, Middle, Last): Augustus Fletcher		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ida Beall	
19a. INFORMANT'S NAME (Type/Print): David Leon Williams	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2625 Naylor Rd., S.E. # 102, Wash., D.C. 20020		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Harmony Mem. Park — DATE: 6/15/95	20c. LOCATION — City or Town, State: Landover, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Larry N. Pratt	22. NAME AND ADDRESS OF FACILITY: H.S. Washington & Sons, inc. 4925 Burroughs Ave., N.E.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such es cerdiac or reepiratory srrest, shock, or heert failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Finel disease or condition resulting in death) →
a. Respiratory Failure
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate csuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Congestive Heart Failure
DUE TO (OR AS A CONSEQUENCE OF):
c. Renal Failure
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Merlyn Vemury MD	29c. LICENSE NUMBER: D35791	29d. DATE SIGNED (Month, Day, Year): ▶ June 12, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Merlyn Vemury, M.D. 9801 Georgia Ave., Silver Spring, Md. 20902

31. DATE FILED (Month, Day, Year): JUN 15 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

AMENDED #1 6/16/95 ELM P.G.C. 95 20352

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ~~Catherine~~ Catherine M. Wallace			2. DATE OF DEATH (Month, Day, Year): June 12, 1995	3. TIME OF DEATH: 8:36 P.M.
4. SOCIAL SECURITY NUMBER: 578-20-0561	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 1/14/14	8. BIRTHPLACE (State or Foreign Country): Wash.,D.C.
9a. FACILITY NAME (If not institution, give street and number): Prince George's Hosp. Center		9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly		9c. COUNTY OF DEATH: P.G.

RESIDENCE OF DECEDENT

10a. STATE: D.C.	10b. COUNTY: N/A	10c. CITY, TOWN OR LOCATION: Washington	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 413 Hamilton St.,N.W.		10f. ZIP CODE: 20011	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Domestic	16b. KIND OF BUSINESS/INDUSTRY: Private Industry	
17. FATHER'S NAME (First, Middle, Last): Alonzo Wright		18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Bernard	
19a. INFORMANT'S NAME (Type/Print): Eva M. Morgan	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7411 Shadyglen Terr.,Cap. Hgts.,Md. 20743		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Harmony Mem. Park DATE: 6/17	20c. LOCATION — City or Town, State: Landover,Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Larry N. Pratt	22. NAME AND ADDRESS OF FACILITY: H.S.Washington & Sons,Inc. 4925 Burroughs Ave.,N.E.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic cerebro-cardiovascular disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

arthritis

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☑ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☑ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Augusto R. Rodriguez MD	29c. LICENSE NUMBER: D21230	29d. DATE SIGNED (Month, Day, Year): June 14, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Augusto R. Rodriguez MD, 5009 Raytown Ct Cap Hgts. Md 20748		
31. DATE FILED (Month, Day, Year): JUN 16 1995	32. REGISTRAR'S SIGNATURE: Julia Dawkins Randall	

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 Rev 1/89

95 20353

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Arvie L. Wrang, Sr.

2. DATE OF DEATH (Month, Day, Year): June 12 1995

3. TIME OF DEATH: 1325 M

4. SOCIAL SECURITY NUMBER: 186-05-3707

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 77 YRS. | IF UNDER 1 YEAR: MONTHS DAYS | IF UNDER 24 HRS.: HOURS MIN.

7. DATE OF BIRTH (Month, Day, Year): 8-4-17

8. BIRTHPLACE (State or Foreign Country): Arizona

9a. FACILITY NAME (If not institution, give street and number): Union Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Elkton

9c. COUNTY OF DEATH: Cecil

RESIDENCE OF DECEDENT

10a. STATE: Md.

10b. COUNTY: Cecil

10c. CITY, TOWN OR LOCATION: Elkton

10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER: 217 West Main Street

10f. ZIP CODE: 21921

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES: WW 2 Korean

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4 or 5+): 2

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Major U.S. Army

16b. KIND OF BUSINESS/INDUSTRY: Armed Forces

17. FATHER'S NAME (First, Middle, Last): John Olaf Wrang

18. MOTHER'S NAME (First, Middle, Maiden Surname): Martha Hendrickson

19a. INFORMANT'S NAME (Type/Print): Nan Mintz Wrang

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 217 West Main St., Elkton, Md. 21921

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Arlington National Cem. DATE: 6/15/95

20c. LOCATION — City or Town, State: Arlington, Va.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: A. D. Kelly

22. NAME AND ADDRESS OF FACILITY: Gee Funeral Home 259 E. Main St., Elkton, Md. 21921

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	cardiac myocard Infarction.	1 h
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b.	old myocard Infarction	
DUE TO (OR AS A CONSEQUENCE OF): c.	Crushed Arteriosclerotic vascular type.	
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Jui Chih Hsu MD

29c. LICENSE NUMBER: D04823.

29d. DATE SIGNED (Month, Day, Year): ▶ 6/13/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jui Chih Hsu MD 223 West main St- Elkton Md 21921

31. DATE FILED (Month, Day, Year): JUN 14 1995

32. REGISTRAR'S SIGNATURE: Julie Davidson Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

NAME Arvie Wrang

12
+1 VA

95 20354

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

10

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARION MAUDE WHEELER		2. DATE OF DEATH (Month, Day, Year): JUNE - 17 - 1995	3. TIME OF DEATH: 6:10 AM
4. SOCIAL SECURITY NUMBER: 219-05-7972	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 88 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 9/14/1906
8. BIRTHPLACE (State or Foreign Country): Maryland			
9a. FACILITY NAME (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER	9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON	9c. COUNTY OF DEATH: BALTIMORE	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Towson	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 615 Chestnut Avenue	10f. ZIP CODE: 21204	10g. CITIZEN OF WHAT COUNTRY?: United States	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Hair Dresser	16b. KIND OF BUSINESS/INDUSTRY: Beauty Parlor	
17. FATHER'S NAME (First, Middle, Last): John H. Richardson	18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Kent		
19a. INFORMANT'S NAME (Type/Print): Helen R. Richardson	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3537 Emory Church Road Street, MD 21154		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Slate Ridge Cemetery	DATE: 6/20	20c. LOCATION — City or Town, State: Delta, PA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jeffrey P. Lovelidge	22. NAME AND ADDRESS OF FACILITY: Harkins Funeral Home, Inc. Delta, PA		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. SEPSIS.	1 week
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): b. Pneumonia.	1 week
	DUE TO (OR AS A CONSEQUENCE OF): c.	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☑

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO
28d. DESCRIBE HOW INJURY OCCURED	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Donald E. Casey Jr MD	29c. LICENSE NUMBER: D 45994	29d. DATE SIGNED (Month, Day, Year): 6/17/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DONALD E. CASEY JR. M.D. GBMC Baltimore		
31. DATE FILED (Month, Day, Year): JUN 20 1995	32. REGISTRAR'S SIGNATURE: Julia Henderson-Randall	

DHMH-18 Rev 1/89

95 20355

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Armon Roland Williams, Sr.			2. DATE OF DEATH (Month, Day, Year): 6 13 95	3. TIME OF DEATH: 7:30 AM
4. SOCIAL SECURITY NUMBER: 216-16-7545	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 4/15/19	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): 9050 Carey RD		9b. CITY, TOWN OR LOCATION OF DEATH: Berlin		9c. COUNTY OF DEATH: Worcester
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY: Worcester	10c. CITY, TOWN OR LOCATION: Berlin		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 9050 Carey RD		10f. ZIP CODE: 21811		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Meat Cutter	16b. KIND OF BUSINESS/INDUSTRY: Grocery Store		
17. FATHER'S NAME (First, Middle, Last): Armon H. Williams		18. MOTHER'S NAME (First, Middle, Maiden Surname): Emily Fisher		
19a. INFORMANT'S NAME (Type/Print): Helen Nock Williams		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9050 Carey RD Berlin, MD 21811		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Evergreen cemetery DATE: 6/15/95	20c. LOCATION — City or Town, State: Berlin, MD		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: W. Fisk Burbage		22. NAME AND ADDRESS OF FACILITY: Burbage Funeral Home 108 Williams St. Berlin, MD 21811		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. metastatic Melanoma	18 mo
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D 20507	29d. DATE SIGNED (Month, Day, Year): 6/13/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Joseph N. Grasso 145 E. Carroll St Salisbury MD

31. DATE FILED (Month, Day, Year): JUN 14 1995	32. REGISTRAR'S SIGNATURE: [signature]

10

DHMH-16 Rev 1/89

95 20356

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARGUERITE ~~M~~ MARIE Woodward				2. DATE OF DEATH (Month, Day, Year): June 11, 1995	3. TIME OF DEATH: 3:30 PM
4. SOCIAL SECURITY NUMBER: 373-18-1617	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 81 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Nov. 7, 1913	8. BIRTHPLACE (State or Foreign Country): Ohio
9a. FACILITY NAME (If not institution, give street and number): Fallston General Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Fallston		9c. COUNTY OF DEATH: Harford
RESIDENCE OF DECEDENT					
10a. STATE: Maryland	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Bel Air			10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1108 Red Pump Rd.		10f. ZIP CODE: 21014		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker		16b. KIND OF BUSINESS/INDUSTRY: Home	
17. FATHER'S NAME (First, Middle, Last): Carl --- Driver			18. MOTHER'S NAME (First, Middle, Maiden Surname): Vesta --- Davis		
19a. INFORMANT'S NAME (Type/Print): Charlene Bennett		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 128 Glenwood Rd., Bel Air, Md. 21014			
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): R.A. Ferris & Co. DATE: 6-16-95		20c. LOCATION — City or Town, State: W. Chester, Pa.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Stephen A. Hercyk		22. NAME AND ADDRESS OF FACILITY: Howard K. McComas III Funeral Home, P.A. 50 W. Broadway St., Bel Air, Md. 21014			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Pneumonia	3 days
DUE TO (OR AS A CONSEQUENCE OF): b.	Aspiration	3 days
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.		
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Supraventricular tachycardia

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER

29c. LICENSE NUMBER: H39022

29d. DATE SIGNED (Month, Day, Year): June 13 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Peter Colucci 1308 Business Cntr Wy Edgewood MD

31. DATE FILED (Month, Day, Year): JUN 15 1995

32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DHMH-16 Rev 1/89

95 20357

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RUBY Lucille WARNER.			2. DATE OF DEATH: MONTH June DAY 16 YEAR 1995	3. TIME OF DEATH: 3:05 p M
4. SOCIAL SECURITY NUMBER: 246-22-9407	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 68 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): March 18 1927	8. BIRTHPLACE (State or Foreign Country): North Carolina
9a. FACILITY NAME (If not institution, give street and number): Southern Maryland Hospital Center		9b. CITY, TOWN OR LOCATION OF DEATH: Clinton	9c. COUNTY OF DEATH: Prince Georges	
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Charles	10c. CITY, TOWN OR LOCATION: Waldorf	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER: 11619 Kipling Drive		10f. ZIP CODE: 20601	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9 / College (1-4 or 5 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Salesperson	16b. KIND OF BUSINESS/INDUSTRY: Retail Clothing		
17. FATHER'S NAME (First, Middle, Last): Lonnie E. Presnell		18. MOTHER'S NAME (First, Middle, Maiden Surname): Bessie L. King		
19a. INFORMANT'S NAME (Type/Print): Patsy A. McKissick		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11619 Kipling Drive Waldorf, MD 20601		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Randolph Memorial Cem. DATE: 6-21-95	20c. LOCATION — City or Town, State: Randleman, N.C.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: M00173		22. NAME AND ADDRESS OF FACILITY: J.H. Eberwein Mortuary 4433 White Pls La White Pls, MD 20695		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE.	5 YRS
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. SEPSIS.	
DUE TO (OR AS A CONSEQUENCE OF):		
	c.	
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE
DIABETES MELLITUS

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☒ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
MD	D28281	▶ 6/16/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): NELSON BENTLEY MD 8926 WOODYARD ROAD, CLINTON, MD 20735

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 19 1995	Julia Davidson-Randall

DHMH 16 Rev 1/89

95 20358

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WILLIAM B. WASS			2. DATE OF DEATH (Month, Day, Year): 6 / 15 / 95	3. TIME OF DEATH: 3:50 PM
4. SOCIAL SECURITY NUMBER: 579-34-0468	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 65 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): February 25, 1930	8. BIRTHPLACE (State or Foreign Country): W. Virginia
9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis		9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Annapolis	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 154 Conduit Street		10f. ZIP CODE: 21401	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: Korean War	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5 +): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Marketing	16b. KIND OF BUSINESS/INDUSTRY: Fire Retardent Chemicals

17. FATHER'S NAME (First, Middle, Last): Dewey S. Wass	18. MOTHER'S NAME (First, Middle, Maiden Surname): Dorsie Hamrick	
19a. INFORMANT'S NAME (Type/Print): Karen K. Wass	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 154 Conduit St., Annapolis, Maryland 21401	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Fort Lincoln Crematory DATE: 6-17	20c. LOCATION — City or Town, State: Brentwood, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St., Annapolis, Md.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Metastatic Rectal Cancer	5 1/2 years
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.		
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Septicemia + Septic Shock

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Ernest W Colen	29c. LICENSE NUMBER: D16354	29d. DATE SIGNED (Month, Day, Year): ▶ 6/15/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 900 BESTGATE RD SUITE 300 ANNAP. Md 21401		
31. DATE FILED (Month, Day, Year): JUN 20 1995	32. REGISTRAR'S SIGNATURE: Julie Davidson Randall	

DHMH-16 Rev 1/89

95 20359

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Williams, Charles		2. DATE OF DEATH (Month, Day, Year): June 17 1995	3. TIME OF DEATH: 1430 M
4. SOCIAL SECURITY NUMBER: 213-22-1527	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 70 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): DEC. 12 1924
8. BIRTHPLACE (State or Foreign Country): MARYLAND			
9a. FACILITY NAME (If not institution, give street and number): ANNE ARUNDEL MEDICAL CENTER	9b. CITY, TOWN OR LOCATION OF DEATH: ANNAPOLIS	9c. COUNTY OF DEATH: ANNE ARUNDEL	
RESIDENCE OF DECEDENT			
10a. STATE: MARYLAND	10b. COUNTY: ANNE ARUNDEL	10c. CITY, TOWN OR LOCATION: ANNAPOLIS	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2130 MULBERRY HILL ROAD	10f. ZIP CODE: 21401	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO; IF YES, GIVE WAR OR DATES: 1943 - 1946	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th; College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MAINTANCE	16b. KIND OF BUSINESS/INDUSTRY: U.S. NAVAL ACADEMY	
17. FATHER'S NAME (First, Middle, Last): JAMES WILLIAMS	18. MOTHER'S NAME (First, Middle, Maiden Surname): EDNA COLBERT		
19a. INFORMANT'S NAME (Type/Print): VIOLA E. WILLIAMS	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2130 MULBERRY HILL RD. ANNAPOLIS, MD. 21401		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): MARYLAND VETERAN CEME. DATE: 6/22/95	20c. LOCATION — City or Town, State: CROWNSVILLE, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Larry G. Reese	22. NAME AND ADDRESS OF FACILITY: REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Respiratory Arrest	6/17/95
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Pneumonia	6/16/95
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Chronic Lymphocytic Leukemia	1986
DUE TO (OR AS A CONSEQUENCE OF):		
d.	Gram Negative Sepsis	6/17/95

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Feb, 1995
Anemia Feb, 1995

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	26a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY M; 26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO; 26d. DESCRIBE HOW INJURY OCCURED
	28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD	29c. LICENSE NUMBER: 032654	29d. DATE SIGNED (Month, Day, Year): 6/17/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John Sorlentsos 180 Admiral Cochrane Dr., Annapolis, MD 21401

31. DATE FILED (Month, Day, Year): JUN 20 1995	32. REGISTRAR'S SIGNATURE: Julie Davidson Randall

DHMH-16 Rev 1/89

95 20360

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Harry Lavier ZIMMERMAN			2. DATE OF DEATH (Month, Day, Year): June 18, 1995	3. TIME OF DEATH: 8:28 P.M.
4. SOCIAL SECURITY NUMBER: 214-10-5048	5. SEX: 1 ☐ M 2 ☐ F	6. AGE (In yrs. last birthday): 79 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Aug. 10, 1915	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick		9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Frederick	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 7326 Ridge Road		10f. ZIP CODE: 21702	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: Mar. 1942 - Oct. 1942	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Seam fitter	16b. KIND OF BUSINESS/INDUSTRY: U. S. Government	
17. FATHER'S NAME (First, Middle, Last): Harry Franklin Zimmerman		18. MOTHER'S NAME (First, Middle, Maiden Surname): Edna Stottlemyer	
19a. INFORMANT'S NAME (Type/Print): Mrs. Octavia Gosnell Zimmerman		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7326 Ridge Road, Frederick, Md. 21702	

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Union Chapel Cemetery	DATE: June 21, 1995	20c. LOCATION — City or Town, State: Libertytown, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Richard C.C. Basford MD0021		22. NAME AND ADDRESS OF FACILITY: Keeney and Basford Funeral Home 106 East Church Street, Frederick, Md. 21701	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	acute upper GI Bleed	17 mos
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. DUE TO (OR AS A CONSEQUENCE OF):	acute anterior MI	1 wk
c. DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

congestive heart failure
renal insufficiency COPD

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURRED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Sherman Kahan MD	29c. LICENSE NUMBER: D12697	29d. DATE SIGNED (Month, Day, Year): June 19, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Sherman Kahan, M.D., 915 Tollhouse Avenue, Frederick, Md. 21701

31. DATE FILED (Month, Day, Year): JUN 21 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DHMH-16 Rev 1/89

ITEM: 26. PER DR. FILM G-725 7/6/95 t.t

95 20361

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ANNIE BALL		2. DATE OF DEATH (Month, Day, Year): JULY 01 1995	3. TIME OF DEATH: 0245 M
4. SOCIAL SECURITY NUMBER: 220-34-7408	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 99 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): July 30, 1895
8. BIRTHPLACE (State or Foreign Country): Virginia			
9a. FACILITY NAME (If not institution, give street and number): University Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore	9c. COUNTY OF DEATH: N/A	
RESIDENCE OF DECEDENT			
10a. STATE: Maryland	10b. COUNTY: N/A	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 2411 Stockton St.	10f. ZIP CODE: 21217	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Warren Jackson	18. MOTHER'S NAME (First, Middle, Maiden Surname): Emma Jackson		
19a. INFORMANT'S NAME (Type/Print): Arlene Watkins	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 597 Baker St. Balto. Md. 21217		
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus DATE: 7/6/95	20c. LOCATION — City or Town, State: Balto. Co Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Joseph L. Russ	22. NAME AND ADDRESS OF FACILITY: Joseph L. Russ Funeral Home 2225 W. North Ave. Balto. Md. 21216		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. PNEUMONIA	5 DAY
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated event resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Alexander Reiss MD	#7812	▶ 7/1/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Alexander Reiss MD 22 S. GREENE ST. BALTIMORE, MD #21201

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUL 06 1995	Julia Thurston Randall

DNMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 20362

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEOENT'S NAME (First, Middle, Last): CLIFFORD L. ANDERSON			2. DATE OF DEATH (Month, Day, Year): Jul 4 1995	3. TIME OF DEATH: 11:08 am M
4. SOCIAL SECURITY NUMBER: 217-03-8489	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): SEPT. 21, 918	8. BIRTHPLACE (State or Foreign Country): OHIO
9a. FACILITY NAME (If not institution, give street and number): Saint Joseph Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH: Towson, Maryland		9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: CARNEY	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 2707 WALDOR DRIVE		10f. ZIP CODE: 21234	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 YRS. College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SELF EMP - OWNER	16b. KIND OF BUSINESS/INDUSTRY: ELECTRICAL COMPANY	
17. FATHER'S NAME (First, Middle, Last): JOHN BEADELL		18. MOTHER'S NAME (First, Middle, Maiden Surname): SARAH TOLSON	
19a. INFORMANT'S NAME (Type/Print): E. LOUISE ANDERSON	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2707 WALDOR DRIVE CARNEY, MARYLAND 2034		
20a. METHOD OF DISPOSITION: [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): MORELAND MEMORIAL PARK DATE: 7-8-95	20c. LOCATION — City or Town, State: PARKVILLE, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD - PARKVILLE		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. RESPIRATORY FAILURE	HOURS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ACUTE CEREBROVASCULAR ACCIDENT	DAYS
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC ATRIAL FIBRILLATION
ASPIRATION PNEUMONIA

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: [X] 1 Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: [X] 1 Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Richard L. Linthicum MD	29c. LICENSE NUMBER: D 31825	29d. DATE SIGNED (Month, Day, Year): 7-6-95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
RICHARD L. LINTHICUM, M.D., ST. JOSEPH MED. CTR., 7620 YORK ROAD, TOWSON, MD. 21204

31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: Julia Miller Rabach

OHMH-16 Rev 1/89

95 20363

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Charles J. Adams			2. DATE OF DEATH (Month, Day, Year): July 4 1995	3. TIME OF DEATH: 1433 M
4. SOCIAL SECURITY NUMBER: 214-01-4714	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 88 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): MAY 13,1907	8. BIRTHPLACE (State or Foreign Country): BALTO., MD
9a. FACILITY NAME (If not institution, give street and number): ST.AGNES HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH: BALTIMORE CITY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 246 THIRD AVENUE		10f. ZIP CODE: 21227	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7TH GRADE; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SUPERVISIOR	16b. KIND OF BUSINESS/INDUSTRY: MARYLAND GLASS	
17. FATHER'S NAME (First, Middle, Last): GEORGE W. ADAMS		18. MOTHER'S NAME (First, Middle, Maiden Surname): LUCY REBECCA FOOTE	
19a. INFORMANT'S NAME (Type/Print): BERNICE SCHNEIDER		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2910 NEW YORK AVENUE - BALTIMORE, MD 21227	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): LOUDON PARK CEMETERY	DATE: 7/7	20c. LOCATION — City or Town, State: BALTIMORE
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Louis E. Smith		22. NAME AND ADDRESS OF FACILITY: HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Congestive heart failure	4 months
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Atrial fibrillation due to Arteriosclerotic cardiovascular ds	1 year
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Bilateral pleural effusion

Paralysis of lower extremities due to collapse of lumbar Spine

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [X]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Lisa M. Kim	29c. LICENSE NUMBER: P 08860	29d. DATE SIGNED (Month, Day, Year): July 4, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 900 South Caton Avenue Baltimore MD 21229

31. DATE FILED (Month, Day, Year): JUL 10 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DHMH-18 Rev 1/89

95 20364

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): George Anthony			2. DATE OF DEATH (Month, Day, Year): June 29 1995	3. TIME OF DEATH: 7:45 P M
4. SOCIAL SECURITY NUMBER: 218-66-1489	5. SEX: 1 M 2 F	8. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): August 9, 1913	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Howard County General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Columbia		9c. COUNTY OF DEATH: Howard County

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Howard County	10c. CITY, TOWN OR LOCATION: Ellicott City	10d. INSIDE CITY LIMITS? 1 YES 2 NO
10e. STREET AND NUMBER: 3000 North Ridge Road		10f. ZIP CODE: 21043	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): n/a	16b. KIND OF BUSINESS/INDUSTRY: n/a	
17. FATHER'S NAME (First, Middle, Last): unknown		18. MOTHER'S NAME (First, Middle, Maiden Surname): unknown	
19a. INFORMANT'S NAME (Type/Print): Howard County Office on Aging		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6751 Columbia Gateway Drive, Columbia, MD 21046	
20a. METHOD OF DISPOSITION: 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place): Good Shepherd Cemetery	DATE: 6-30-95	20c. LOCATION — City or Town, State: Ellicott City, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] M00535	22. NAME AND ADDRESS OF FACILITY: Slack Funeral Home, P.A. Ellicott City, Maryland 21043		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Congestive Heart Failure	1 day
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Dilated cardiomyopathy	years
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive lung disease

Chronic lymphocytic leukemia

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☒ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 8 Other (Specify)	
27. MANNER OF DEATH: 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 8 Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 YES 2 NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D04345	29d. DATE SIGNED (Month, Day, Year): June 30, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles E. Taylor MD 2 Knoll North Drive Columbia MD 21045		
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: [signature]	

DHMH-16 Rev 1/89

95 20365

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CARLO J. AIMONE			2. DATE OF DEATH (Month, Day, Year): JULY 5, 1995	3. TIME OF DEATH: 1:05 am M
4. SOCIAL SECURITY NUMBER: 140-36-0230	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 92 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Feb. 18, 1903	8. BIRTHPLACE (State or Foreign Country): New Jersey
9a. FACILITY NAME (If not institution, give street and number): Aah-Tul Care, Ltd.		9b. CITY, TOWN OR LOCATION OF DEATH: Columbia		9c. COUNTY OF DEATH: Howard County

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Howard County	10c. CITY, TOWN OR LOCATION: Ellicott City	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: 3902 MacAlpine Road		10f. ZIP CODE: 21042	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Attorney	16b. KIND OF BUSINESS/INDUSTRY: Federal Government
17. FATHER'S NAME (First, Middle, Last): Carlo J. Aimone		18. MOTHER'S NAME (First, Middle, Maiden Surname): Columba Giuffra	
19a. INFORMANT'S NAME (Type/Print): Ms. Celeste Scanlon		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3902 MacAlpine Road, Ellicott City, MD 21042	

20a. METHOD OF DISPOSITION: [X] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Fairview Cemetery & Mausoleum	DATE: 7-8-95	20c. LOCATION — City or Town, State: Fairview, NJ
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: M00535		22. NAME AND ADDRESS OF FACILITY: Slack Funeral Home, P.A. Ellicott City, Maryland 21043	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	cardiomyopathy	10yrs
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	alzemer's dementia	10yrs
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: metastatic prostate cancer

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D26621	29d. DATE SIGNED (Month, Day, Year): 7/5/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 3460 Ellicott Center Drive, Ellicott City, Md. 21043		
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE	

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95 20366

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MYRTLE Y. ALT		2. DATE OF DEATH (Month, Day, Year): July 4 1995	3. TIME OF DEATH: 2:45P M
4. SOCIAL SECURITY NUMBER: 212-50-6112	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 96 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): June 13, 1899
8. BIRTHPLACE (State or Foreign Country): Maryland			
9a. FACILITY NAME (If not institution, give street and number): Charlestown Retirement Center	9b. CITY, TOWN OR LOCATION OF DEATH: Catonsville	9c. COUNTY OF DEATH: Baltimore	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Catonsville	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 711 Maiden Choice Lane	10f. ZIP CODE: 21228	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Charles William Yentner	18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine Gerlack		
19a. INFORMANT'S NAME (Type/Print): Carole Timanus (Daughter)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1016 Elm Road Baltimore, Maryland 21227		
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Cemetery DATE: July 8, 1995	20c. LOCATION — City or Town, State: Dorsey, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: R. Clay Witzke	22. NAME AND ADDRESS OF FACILITY: Leroy M & Russell C Witzke Funeral Homes 1630 Edmondson Avenue Catonsville Maryland		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Dehydration	weeks
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Diarrhea / Decreased Oral Intake	weeks
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Probable GI malignancy

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Bernard F Kozlovsky	29c. LICENSE NUMBER: D26473	29d. DATE SIGNED (Month, Day, Year): July 5, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Bernard F. Kozlovsky, MD 711 Maiden Choice Lane Balto, MD 21228		
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: Judith Brudenell	

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95 20367

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Thomas T. Armstrong Sr.
2. DATE OF DEATH — MONTH: July DAY: 4 YEAR: 1995
3. TIME OF DEATH: 10:45 AM
4. SOCIAL SECURITY NUMBER: 212-03-7551
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 90 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Feb. 12, 1905
8. BIRTHPLACE (State or Foreign Country): Sweden
9a. FACILITY NAME (If not institution, give street and number): Lorien Nursing Center
9b. CITY, TOWN OR LOCATION OF DEATH: Columbia
9c. COUNTY OF DEATH: Howard

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Reisterstown
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 113 Second Ave.
10f. ZIP CODE: 21136
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): 2
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Manager
16b. KIND OF BUSINESS/INDUSTRY: Meat Packing
17. FATHER'S NAME (First, Middle, Last): Andrew Armstrong
18. MOTHER'S NAME (First, Middle, Maiden Surname): Johanna Neilson
19a. INFORMANT'S NAME (Type/Print): Robert M. Armstrong
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9321 Ramsey Dr. Ellicott City, Md. 21042
20a. METHOD OF DISPOSITION: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Druid Ridge Cemetery — DATE: 7-7-95
20c. LOCATION — City or Town, State: Pikesville, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James B Eline
22. NAME AND ADDRESS OF FACILITY: Eline Funeral Home — 11824 Reisterstown Road Reisterstown, Md. 21136

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. METASTATIC CARCINOMA	Few Months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY:
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: N.B. Vellanki MD
29c. LICENSE NUMBER: D.30469
29d. DATE SIGNED (Month, Day, Year): ▶ July 4 - 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): N.B. VELLANKI MD. 7055 CHEVROLET DRIVE #100 ELLICOTT CITY MD 21042

31. DATE FILED (Month, Day, Year): JUL 06 1995
32. REGISTRAR'S SIGNATURE: Julie Davidson Randall

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95 20368

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Victoria Brown			2. DATE OF DEATH (Month, Day, Year): July 05 1995	3. TIME OF DEATH: 0512 M
4. SOCIAL SECURITY NUMBER: unknown	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS 1, DAYS 26 — IF UNDER 24 HRS.: HOURS, MIN.	7. DATE OF BIRTH (Month, Day, Year): 5-9-95	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): University Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH: None

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: None	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1501 Edmondson Ave.		10f. ZIP CODE: 21223	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0 — College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): None	16b. KIND OF BUSINESS/INDUSTRY: None	
17. FATHER'S NAME (First, Middle, Last): Johnnie Brown		18. MOTHER'S NAME (First, Middle, Maiden Surname): Desiree Lee	
19a. INFORMANT'S NAME (Type/Print): Desiree Lee		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1501 Edmondson Ave. Balto., Md. 21223	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Zion — DATE: 7-8	20c. LOCATION — City or Town, State: Landsdowne, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Derrick C. Jones		22. NAME AND ADDRESS OF FACILITY: Derrick C. Jones Funeral Home 4611 Park Heights Ave.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Sudden Infant Death Syndrome	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Dennis J. Cluster	29c. LICENSE NUMBER: O.C.M.E.	29d. DATE SIGNED (Month, Day, Year): July 05 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 111 Penn Street, Baltimore, Maryland 21201		
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: Julia Whitten Nevell	

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95 20369

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GEORGE STEWART BELT			2. DATE OF DEATH (Month, Day, Year): JUNE 24, 1995	3. TIME OF DEATH: 10:30 A.M.
4. SOCIAL SECURITY NUMBER: 166-01-3727	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 89 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): AUG 31 1905	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): HART HERITAGE HOME		9b. CITY, TOWN OR LOCATION OF DEATH: STREET		9c. COUNTY OF DEATH: HARFORD

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: PARKVILLE	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO	
10e. STREET AND NUMBER: 3606 DAVID AVE.		10f. ZIP CODE: 21234	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 YRS. College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): FOREMAN	16b. KIND OF BUSINESS/INDUSTRY: SHOE BUSINESS		
17. FATHER'S NAME (First, Middle, Last): WALTER S. BELT	18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY ELIZABETH WEHN			
19a. INFORMANT'S NAME (Type/Print): MILDRED E. BAXTER	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3606 DAVID AVE. PARKVILLE, MARYLAND 21234			
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): GREEN MOUNT CREMATORY DATE: 6-27-95	20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: EVANS CHAPEL OF MEMORIES 7800 HARFORD ROAD — PARKVILLE			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. COLON CANCER	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D39859	29d. DATE SIGNED (Month, Day, Year): JUNE 26, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR ALFRED SPARKS. 2105 LAUREL BUSH ROAD BEL AIR, MARYLAND 21014		
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. [illegible]	

DHMH-16 Rev 1/89

95 20370

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Donald BEHLER Sr.					2. DATE OF DEATH (Month, Day, Year): July 3, 1995	3. TIME OF DEATH: 1:40 P M
4. SOCIAL SECURITY NUMBER: 191-14-2730	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 71 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 5-25-24	8. BIRTHPLACE (State or Foreign Country): PA
9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Rossville		9c. COUNTY OF DEATH: Baltimore	

RESIDENCE OF DECEDENT

10a. STATE: Md	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Middle River	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1211 Orems Rd.		10f. ZIP CODE: 21220	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Metal Finisher	16b. KIND OF BUSINESS/INDUSTRY: Automobile
17. FATHER'S NAME (First, Middle, Last): Jonn Behler		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Snyder	
19a. INFORMANT'S NAME (Type/Print): Ida Mae Behler		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1211 Orems Rd. Middle River, MD 21220	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith DATE: 7-6-95	20c. LOCATION — City or Town, State: Baltimore, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Denis S. Kelly		22. NAME AND ADDRESS OF FACILITY: Cvach/Rosedale Funeral Home 1211 Chesaco Ave.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Intracerebral Hemorrhage	12 hours
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	OUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [X]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: 036951	29d. DATE SIGNED (Month, Day, Year): ▶ 7/4/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jeffrey Schluederberg, MD 1012 Old North Point Rd. Baltimore Md. 21224		
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson Rodell	

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OHMH-16 Rev 1/89

95 20371

FilmG, 725, item #20b, 7/6/95, cyw, per f.h.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): NORMA JEAN BARILLA					2. DATE OF DEATH (Month, Day, Year): June 29, 1995	3. TIME OF DEATH: 3:00 A M
4. SOCIAL SECURITY NUMBER: 216-44-5998	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 49 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Jan 18, 1946	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 7894 Americana Cl., Apt. T3			9b. CITY, TOWN OR LOCATION OF DEATH: Glen Burnie		9c. COUNTY OF DEATH: Anne Arundel	
RESIDENCE OF DECEDENT						
10a. STATE: Maryland	10b. COUNTY: Anne Arundel		10c. CITY, TOWN OR LOCATION: Glen Burnie		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO	
10e. STREET AND NUMBER: 7894 Americana Circle, Apt. T3			10f. ZIP CODE: 21060		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5 +):			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Retired District Court Clerk		16b. KIND OF BUSINESS/INDUSTRY: State of Maryland	
17. FATHER'S NAME (First, Middle, Last): Franklin C. Long					18. MOTHER'S NAME (First, Middle, Maiden Surname): Dorothy E. Speacht	
19a. INFORMANT'S NAME (Type/Print): Mr. John Sinnott			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7894 Americana Cl., Apt. T3, Glen Burnie, Md. 21060			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery 7/3/95 DATE ~~7/4/95~~		20c. LOCATION — City or Town, State: Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Kevin E. Ecker			22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mods of dying, such es cardiec or respiratory srrest, shock, or hesrt fellure. List only one ceuee on eech line.

Approximate Interval Between Onset end Death

IMMEDIATE CAUSE (Finel disease or condition resulting in death) → a. VENTricular arrhythmia

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Coronary artery Disease

DUE TO (OR AS A CONSEQUENCE OF):

c. Diabetes Mellitus

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hyperlipidemia

Peripheral Vascular Disease

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☒ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

28. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

26a. DATE OF INJURY (Month, Day, Year)

26b. TIME OF INJURY M

26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

26d. DESCRIBE HOW INJURY OCCURED

28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Gerard M. Lowder M.D.	D29296	▶ JUNE 30, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Gerard Lowder, M.D. 707 East Fort Ave., Baltimore, Maryland 21230

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUL 06 1995	Julia Sheridan-Randall

DHMH-16 Rev 1/89

95 20372

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDEHT'S HAME (First, Middle, Last): MARY L BAXTER			2. DATE OF DEATH (Month, Day, Year): JUNE 30 1995	3. TIME OF DEATH: 9:15 PM
4. SOCIAL SECURITY HUMBER: 251-46-0854	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 67 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Aug 26, 1927	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY HAME (If not institution, give street and number): Harbor Hospital Center		9b. CITY, TOWN OR LOCATION OF DEATH: Balto.City,Md.		9c. COUNTY OF DEATH: none
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: none	10c. CITY, TOWH OR LOCATION: Balto.City,Md.		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ HO
10e. STREET AHD HUMBER: 1645 Jackson St.		10f. ZIP CODE: 21230		10g. CITIZEH OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IH U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDEHT OF HISPANIC ORIGIN? (Specify Yes or Ho— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th.Grade; College (1-4 or 5+): none		16a. DECEDEHT'S USUAL OCCUPATIOH (Give kind of work done during most of working life. Do NOT use retired.): Homemaker		16b. KIND OF BUSINESS/INDUSTRY: Own Home
17. FATHER'S HAME (First, Middle, Last): Gardiner Parks		18. MOTHER'S NAME (First, Middle, Maiden Surname): Vida Garner		
19a. IHFORMANT'S HAME (Type/Print): Mrs.Alice E.Guthries		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1440 Marshall St.Balto.Md.21230		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or othar place): Cedar Hill Cemetery, 7/5/95	DATE	20c. LOCATION — City or Town, State: Balto.Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Daniel A. Taylor		22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home, 130 E.Fort Ave. Balto.Md.21230		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the moda of dying, auch aa cerdiec or reapiratory arrest, ahock, or heart feilure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition resulting in death) →	e. Metastatic Carcinoma lung	Dxed 10days ago
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Chronic Obstructive Pulmonary Disease	>20yrs
DUE TO (OR AS A CONSEQUENCE OF):		
	c.	
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART II. Othar significent conditiona contributing to death but not resulting in the underlying ceuse given in Part I.

Coronary Artery Disease
Hx of heavy smoking

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Abhidhar House staff	29c. LICEHSE NUMBER: AS244161A-11	29d. DATE SIGNED (Month, Day, Year): ▶ June 30th 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DrSRIDHAR ATLURI Harbor Hospital Center, 3001 S HANOVER ST BALTIMORE MD 21225		
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: Julia	

DHMH-16 Rev 1/89

95 20373

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN M. BRIDGE			2. DATE OF DEATH (Month, Day, Year): JULY 2, 1995	3. TIME OF DEATH: 8:55 P M
4. SOCIAL SECURITY NUMBER: 218-05-3938	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 80 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): APRIL 10, 1915	8. BIRTHPLACE (State or Foreign Country): BALTIMORE, MARYLAND
9a. FACILITY NAME (If not institution, give street and number): 2932 KNOLL ACRES DRIVE		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE COUNTY		9c. COUNTY OF DEATH: BALTIMORE
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: BALTIMORE COUNTY		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 2932 KNOLL ACRES DRIVE		10f. ZIP CODE: 21234		10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+): N/A	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): TRUCK DRIVER		16b. KIND OF BUSINESS/INDUSTRY: TRUCKING INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): ARTHUR BRIDGE			18. MOTHER'S NAME (First, Middle, Maiden Surname): LILLIAN WINTER	
19a. INFORMANT'S NAME (Type/Print): VIRGINIA B. BRIDGE		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2932 KNOLL ACRES DRIVE BALTIMORE, MARYLAND 21234		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): LORRAINE PARK CEMETERY JULY 7, 1995		20c. LOCATION — City or Town, State: WOODLAWN, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: LASSAHN FUNERAL HOME, INC. 7401 BELAIR ROAD BALTIMORE, MARYLAND 21236-4625			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. adeno carcinoma of lung	4 Mos
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D10091	29d. DATE SIGNED (Month, Day, Year): 7/5/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Arthur A Sergiell MD St Joseph Med Cntr Towson MD		
31. DATE FILED (Month, Day, Year): JUL 0 6 1995	REGISTRAR'S SIGNATURE: [signature]	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

124

95 20374

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ronald Edward BECK			2. DATE OF DEATH: Month July, Day 04, Year 1995	3. TIME OF DEATH: 11:52 pM
4. SOCIAL SECURITY NUMBER: 220-30-3279	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 60 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): MAY 22, 1935	8. BIRTHPLACE (State or Foreign Country): BALTIMORE CO., MD.
9a. FACILITY NAME (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE COUNTY		9c. COUNTY OF DEATH: Baltimore
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE CITY	10c. CITY, TOWN OR LOCATION: BALTIMORE		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 710 NORTH WOODWARD DRIVE		10f. ZIP CODE: 21221		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HEAVY EQUIPMENT OPERATOR		16b. KIND OF BUSINESS/INDUSTRY: C.J. LANGENFELDER & SON
17. FATHER'S NAME (First, Middle, Last): GEORGE EDWARD BECK			18. MOTHER'S NAME (First, Middle, Maiden Surname): ZELDA M. ROTHERMEL	
19a. INFORMANT'S NAME (Type/Print): BETTY J. BECK		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 710 NORTH WOODWARD DRIVE BALTIMORE, MARYLAND 21221		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): PARKWOOD CEMETERY JULY 7, 1995	DATE	20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Heather Lassahn		22. NAME AND ADDRESS OF FACILITY: LASSAHN FUNERAL HOME, INC. 7401 BELAIR ROAD BALTIMORE, MARYLAND 21236-4625		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Anoxic encephalopathy	6 days
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Ventricular fibrillation	6 days
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Coronary artery disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.: Hypertension

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Rodney W. Brooks, M.D.	R D 001813	▶ July 04, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Rodney Brooks M.D. 9000 Franklin Square Drive Baltimore Md. 21237-3998

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUL 06 1995	Julia Lawson Revak

1041

DNMN-16 Rev 1/89

95-3581-025
blh

ITEM: 4. PER STATE ANATOMY BOARD FILM G-726 8/31/95 t.t

95 20375

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Beatrice Edna Jackson Buck			2. DATE OF DEATH (Month, Day, Year): June 19 1995	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: ~~217-01-8150~~	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 84 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 21, 11	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 3413 Webster Road		9b. CITY, TOWN OR LOCATION OF DEATH:	9c. COUNTY OF DEATH: Harford	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Havre De Grace	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 4134 Webster Road		10f. ZIP CODE: 21078	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 1	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): Andrew J. Jackson		18. MOTHER'S NAME (First, Middle, Maiden Surname): Edna M. Reynolds	
19a. INFORMANT'S NAME (Type/Print): Helen B. Walke		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4134 Webster Rd., Havre De Grace, MD 21078	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald Wade, Dir.		22. NAME AND ADDRESS OF FACILITY: State Anatomy Board 655 W. Baltimore St., Balto., MD 21201	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Hypertensive Arteriosclerotic Cardiovascular Disease	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	a. DUE TO (OR AS A CONSEQUENCE OF):	
	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURED
			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: O.C.M.E.	29d. DATE SIGNED (Month, Day, Year): June 20 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): David R. Fowler, MD. 111 Penn Street, Baltimore, Maryland 21201		
31. DATE FILED (Month, Day, Year): JUN 30 1995	32. REGISTRAR'S SIGNATURE: Lucy Randall	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 20376

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Beverly Carter			2. DATE OF DEATH (Month, Day, Year): June 27, 1995	3. TIME OF DEATH: 8:40p M
4. SOCIAL SECURITY NUMBER: 212-76-8355	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 37 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 02 08 58	8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): Sinai Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City	9c. COUNTY OF DEATH: NA

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: NA	10c. CITY, TOWN OR LOCATION: Baltimore City	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2849 W. Coldspring Lane	10f. ZIP CODE: 21215		10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+): NA	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Custodian	16b. KIND OF BUSINESS/INDUSTRY: Janitorial Services	
17. FATHER'S NAME (First, Middle, Last): James Leroy Carter, Sr.	18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Williams Carter		
19a. INFORMANT'S NAME (Type/Print): Vonte Thomas/Sherri Thomas	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2849 W. Coldspring Ln. Balto, MD 21215		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Mount Zion Cem. DATE: 7/3/95	20c. LOCATION — City or Town, State: Baltimore, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph R. Walters, Jr.	22. NAME AND ADDRESS OF FACILITY: Unity Funeral Home 108 W. North Avenue Balto, MD 21201		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Herniation of Intracranial Hemorrhage	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. HIV	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. HIV (+)	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: David C. Ting, M.D.	29c. LICENSE NUMBER: AS240321T9910	29d. DATE SIGNED (Month, Day, Year): June 27 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): David C. Ting, M.D. Sinai Hospital of Baltimore MD

31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: [illegible]

DHMH-16 Rev 1/89

95 20377

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ALBERT CONJOUR			2. DATE OF DEATH (Month, Day, Year): JULY - 04 1995	3. TIME OF DEATH: 10:30P M
4. SOCIAL SECURITY NUMBER: 218-01-3627	5. SEX: 1 XX M 2 ☐ F	6. AGE (In yrs. last birthday): 77 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 9, 1918	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Northwest Hospital Center		9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown		9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Hebbville	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3136 Rolling Road		10f. ZIP CODE: 21244	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 XX Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Caucasian

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): -	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Steam Fitter	16b. KIND OF BUSINESS/INDUSTRY: Local #438	
17. FATHER'S NAME (First, Middle, Last): Leon Joseph Conjour		18. MOTHER'S NAME (First, Middle, Maiden Surname): Gertrude Weisse	
19a. INFORMANT'S NAME (Type/Print): Charles R. Conjour	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Cocoa Beach, 3873 South Banana River Blvd. #301 Florida 32931		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place): Druid Ridge Cemetery July	DATE: 8,1995	20c. LOCATION — City or Town, State: Pikesville, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Joseph J. W. Kellner	22. NAME AND ADDRESS OF FACILITY: Loring Byers Funeral Directors, INC. 8728 Liberty Rd Randallstown, MD 21133-4784		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CENTRAL SLEEP APNOEA	4-5 yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☑ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Signature	29c. LICENSE NUMBER: D40491	29d. DATE SIGNED (Month, Day, Year): ▶ July. 04. 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Signed M A Roy M W H C Randallstown MD 21133		
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: [illegible]	

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DHMH-16 Rev 1/89

95 20378

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Jesse Woodrow COOK			2. DATE OF DEATH (Month, Day, Year): July 04 1995	3. TIME OF DEATH: 11:30 pM
4. SOCIAL SECURITY NUMBER: 219 05 0111	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 82 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 6,1913	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Rossville	9c. COUNTY OF DEATH: Baltimore	
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Middle River	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO	
10e. STREET AND NUMBER: 5 Decatur Road		10f. ZIP CODE: 21221	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer	16b. KIND OF BUSINESS/INDUSTRY: Steel Company		
17. FATHER'S NAME (First, Middle, Last): Parks Cook	18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie Cook			
19a. INFORMANT'S NAME (Type/Print): Mary Cook	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5 Decatur Road Middle River, Md 21220			
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith Cem. DATE: 7/7/1995	20c. LOCATION — City or Town, State: Baltimore County, Md		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: Bruzdzinski Funeral Home P.A. 1407 Eastern Ave Baltimore, Maryland 21221			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pneumonia	2 days
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive heart failure

Stroke

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [X] NO [ ] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	M		

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Hossin Assadi DO	R D 001911	▶ July 04, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Hossin Assadi M.D. 9000 Franklin Square Drive Baltimore Md. 21237-3998

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUL 06 1995	Julie Gardner-Randall

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DHMH-16 Rev 1/89

95 20379

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): John Coligny			2. DATE OF DEATH (Month, Day, Year): June 30, 1995	3. TIME OF DEATH: 630 PM
4. SOCIAL SECURITY NUMBER: 212-05-3905	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 82 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): June 8, 1913	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 1605 Bluffdale Road Apt. A		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore County		9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Baltimore County	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1605 Bluffdale Road Apt. A		10f. ZIP CODE: 21244	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10 Years; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Sgt.	16b. KIND OF BUSINESS/INDUSTRY: Balto. City Police Dept.	
17. FATHER'S NAME (First, Middle, Last): Warren H. Coligny		18. MOTHER'S NAME (First, Middle, Maiden Surname): Katherine Schopf	
19a. INFORMANT'S NAME (Type/Print): Mr. Warren DeColigny		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3908 Susanna Road Randallstown, Maryland 21133	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Lorraine Park Cemetery; DATE: 7/8	20c. LOCATION — City or Town, State: Woodlawn, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Stephen M Jenkins		22. NAME AND ADDRESS OF FACILITY: Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Carcinoma of tongue with metastases.	2 yrs.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)	1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.		
29b. SIGNATURE AND TITLE OF CERTIFIER: Herman Brecher M.D.		29c. LICENSE NUMBER: D01317	29d. DATE SIGNED (Month, Day, Year): ▶ 7/6/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Herman Brecher 6440 Windsor Mill Rd 21207			
31. DATE FILED (Month, Day, Year): JUL 06 1995	REGISTRAR'S SIGNATURE: [illegible]		

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DHMH-16 Rev 1/89

95 20380

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH (Month / Day / Year)	3. TIME OF DEATH
Goldie Cottrell Carlton (Coulton)				7 / 4 / 95	10:00 PM
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
243-28-2838	1 ☐ M 2 ☒ F	78 YRS.		April 11, 1917	North Carolina
9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN OR LOCATION OF DEATH		9c. COUNTY OF DEATH	
3100 Caudle Drive		Mt Airy		Carroll	
RESIDENCE OF DECEDENT					
10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS?	
Maryland	Carroll	Mt. Airy		1 ☐ YES 2 ☒ NO	
10e. STREET AND NUMBER		10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?	
3100 Caudle Drive		21771		U.S.A.	
11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES?	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)		14. RACE — American Indian, Black, White, etc.	
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	1 ☐ YES 2 ☒ NO Specify:		Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
Elementary/Secondary (0-12): 12 Years; College (1-4 or 5+):		Housewife		Own Home	
17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NAME (First, Middle, Maiden Surname)			
William Cottrell		Bertie Unknown			
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
Mrs. Carol Ann Caudle		3101 Caudle Drive Mt. Airy, Maryland 21771			
20a. METHOD OF DISPOSITION 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State	
		Carroll Cremation Services	7/6	Hampstead, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FACILITY			
▶ Stephen McJenkin		Burrier-Queen Funeral Directors, P.A. 1212 W Old Liberty Road Winfield, MD 21784			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Atherosclerotic Cardiovascular Disease	4 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Richard L. Jones MD	D05905	▶ 5 Jul. 95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. Richard Jones, MD; CCHH 200 Memorial Avenue Westminster, MD

31. DATE FILED (Month, Day, Year)	REGISTRAR'S SIGNATURE
JUL 06 1995	

DHMH-16 Rev 1/89

95 20381

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Anna Ruth Cohen			2. DATE OF DEATH (Month, Day, Year): July 2, 1995	3. TIME OF DEATH: 5:30P M
4. SOCIAL SECURITY NUMBER: 217-03-1804	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 80 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Jan. 22, 1915	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Heritage Meridian Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: Dundalk	9c. COUNTY OF DEATH: Baltimore	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Dundalk	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 7232 German Hill Road		10f. ZIP CODE: 21222	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9 Years; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Telephone Operator	16b. KIND OF BUSINESS/INDUSTRY: Communications	
17. FATHER'S NAME (First, Middle, Last): James Leonard Collins		18. MOTHER'S NAME (First, Middle, Maiden Surname): Willie Ruth Burton	
19a. INFORMANT'S NAME (Type/Print): Gloria L. Feibel	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1713 Watervale Avenue Baltimore, Maryland 21222		
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Moreland Mem. Pk. Cem. DATE: 7/6/1995	20c. LOCATION — City or Town, State: Baltimore, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]	22. NAME AND ADDRESS OF FACILITY: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Alzheimers Disease	5 years
	DUE TO (OR AS A CONSEQUENCE OF): Hypertension	10 years
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURED
			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Harjit Singh (Attending Physician) M.D.	29c. LICENSE NUMBER: D14160	29d. DATE SIGNED (Month, Day, Year): ▶ 07/03/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Harjit Singh, M.D. 5410-A Ritchie Highway Baltimore, Md. 21225			
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: [signature]		

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DHMH-16 Rev 1/89

95 20382

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MORRIS CHOSAK				2. DATE OF DEATH Month: JULY Day: 1 Year: 95	3. TIME OF DEATH: 8:20 A M
4. SOCIAL SECURITY NUMBER: 088-05-5182	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 85 YRS.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.	7. DATE OF BIRTH (Month, Day, Year): DEC. 18, 1909
8. BIRTHPLACE (State or Foreign Country): LATVIA					
9a. FACILITY NAME (If not institution, give street and number): SINAI HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH: N/A	
RESIDENCE OF DECEDENT					
10a. STATE: MARYLAND	10b. COUNTY: N/A	10c. CITY, TOWN OR LOCATION: BALTIMORE		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO	
10e. STREET AND NUMBER: 3615 FORDS LANE, APT. #702		10f. ZIP CODE: 21215		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10 / College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PROPRIETOR		16b. KIND OF BUSINESS/INDUSTRY: GROCERY	
17. FATHER'S NAME (First, Middle, Last): JOSHUA CHOSAK		18. MOTHER'S NAME (First, Middle, Maiden Surname): CHAYA BIRZANSKY			
19a. INFORMANT'S NAME (Type/Print): MR. JERRY CHOSAK		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 20 HIGH SIDE COURT, OWINGS MILLS, MD. 21117			
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): SHAAREI ZION CONG. DATE: 7/3/95		20c. LOCATION — City or Town, State: ROSEDALE, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Allenson Levinson		22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD. 21215			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. RECURRENT GASTRIC CANCER.	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO	

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO
28d. DESCRIBE HOW INJURY OCCURRED: RECURRENT GASTRIC CANCER	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): BALTO MD	

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Bahadursingh MD	29c. LICENSE NUMBER: D00882	29d. DATE SIGNED (Month, Day, Year): ▶ JULY 1, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. BAHADURSINGH Sinai Hospital - Greenspring & Belvedere Aves., Balto. md. 21215		
31. DATE FILED (Month, Day, Year): JUL 06 1995	REGISTRAR'S SIGNATURE: Julia	

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DHMH-16 Rev 1/89

95 20383

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): PHILIP B. COULTER				2. DATE OF DEATH (Month, Day, Year): Jul 2 1995	3. TIME OF DEATH: 10:30 pm M
4. SOCIAL SECURITY NUMBER: 230-07-0484	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 77 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): May 21, 1918	8. BIRTHPLACE (State or Foreign Country): Delaware
9a. FACILITY NAME (If not institution, give street and number): Saint Joseph Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH: Towson, Maryland	9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Parkville/Carney	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 7903 Ridgely Oak Rd.		10f. ZIP CODE: 21234	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 yrs; College (1-4 or 5+): 4 yrs		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Chemist	16b. KIND OF BUSINESS/INDUSTRY: U. S. Army
17. FATHER'S NAME (First, Middle, Last): Thomas Coulter		18. MOTHER'S NAME (First, Middle, Maiden Surname): Gladys Birch	
19a. INFORMANT'S NAME (Type/Print): Mrs. Martha E. Coulter		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7903 Ridgely Oak Rd. Baltimore, Maryland 21234	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cemetery DATE: 7-6-95	20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Heather Lassahn		22. NAME AND ADDRESS OF FACILITY: Lassahn Funeral Home 7401 Belair Rd. Baltimore, Maryland 21236	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. METASTATIC SIGMOID CARCINOMA	9 months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

GASTROINTESTINAL BLEEDING
SEPSIS

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Joginder P Metha MD	29c. LICENSE NUMBER: D 41410	29d. DATE SIGNED (Month, Day, Year): 07-03-95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOGINDER P. METHA M.D. ST. JOSEPHS MEDICAL CENTER 7620 YORK RD TOWSON, MD 21204

31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: Julie Weissenhorn

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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95 20384

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Roger L. CRALLE				2. DATE OF DEATH (Month, Day, Year): June 6 1995	3. TIME OF DEATH: 5 PM
4. SOCIAL SECURITY NUMBER: 214-22-5911	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 96 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 8-9-1898	8. BIRTHPLACE (State or Foreign Country): VIRGINIA
9a. FACILITY NAME (If not institution, give street and number): Seton Hill Manor		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH: BALTIMORE CITY	
RESIDENCE OF DECEDENT					
10a. STATE: MD	10b. COUNTY: BALTIMORE CITY	10c. CITY, TOWN OR LOCATION: BALTIMORE		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO	
10e. STREET AND NUMBER: 501 W. FRANKLIN Street		10f. ZIP CODE: 21201		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) in state		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald Wade, Dir. ▶ Ronald J Wade		22. NAME AND ADDRESS OF FACILITY: State Anatomy Board 655 W. Baltimore St., Balto., MD 21201			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	e. Metastic Prostate CANCER	years
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Jay Hunter Copeland MD	29c. LICENSE NUMBER: D27034	29d. DATE SIGNED (Month, Day, Year) ▶ JUNE 23 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jay Hunter Copeland MD 5310 Old Court Road Suite 201 Randallstown MD 21133		
31. DATE FILED (Month, Day, Year): JUN 30 1995	32. REGISTRAR'S SIGNATURE: Marilyn Randall	

DHMH-16 Rev 1/89

95 20385

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Thomas CAMMARATA JR.			2. DATE OF DEATH (Month, Day, Year): June 29 1995	3. TIME OF DEATH: 1:44 P M
4. SOCIAL SECURITY NUMBER: 213 20 2659	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 64 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Aug. 22, 1930	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore	9c. COUNTY OF DEATH: Baltimore	
RESIDENCE OF DECEDENT					
10a. STATE: Md.	10b. COUNTY: Carroll	10c. CITY, TOWN OR LOCATION: Sykesville		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO	
10e. STREET AND NUMBER: Main Street		10f. ZIP CODE: 21784		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): High School; College (1-4 or 5+): 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): None		16b. KIND OF BUSINESS/INDUSTRY: None	
17. FATHER'S NAME (First, Middle, Last): Thomas Cammarata Sr.			18. MOTHER'S NAME (First, Middle, Maiden Surname): Josephone Serio		
19a. INFORMANT'S NAME (Type/Print): Springfield Hospital Records		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Main St. Sykesville, Md. 21784			
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Springfield Hos Cemetery DATE: 7/1/95		20c. LOCATION — City or Town, State: Sykesville, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Brian K. Haight			22. NAME AND ADDRESS OF FACILITY: Haight Funeral Home P.O.Box 195 Sykesville, Md. 21784		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory failure	1 week
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Pseudamonas sepsis	1 week
DUE TO (OR AS A CONSEQUENCE OF):		
	c. Pseudamonas pneumonia	3 weeks
DUE TO (OR AS A CONSEQUENCE OF):		
	d. Chronic obstructive pulmonary disease	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Malnutrition, Gastrointestinal bleeding, tardive dyskinesia, paranoid schizophrenia

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [X] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Karen Moffett M.D.	29c. LICENSE NUMBER: P08543	29d. DATE SIGNED (Month, Day, Year): ▶ June 29, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Karen Moffett, M.D. 9000 Franklin Square Drive Baltimore, MD 21237		
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: Julia Pierson-Randall	

DHMH-16 Rev 1/89

95-3841-510
B.K.S

95 20386

Item1 7-6-95 FilmG725 W.H.Per F/H

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ~~ORCE~~ ~~DUNCAN~~ Orce Wilson Duncan Sr.

2. DATE OF DEATH (Month, Day, Year): JULY 02, 1995

3. TIME OF DEATH: 0820 AM

4. SOCIAL SECURITY NUMBER: 227-34-3052

5. SEX: 1 ☒ M 2 ☐ F

6. AGE (In yrs. last birthday): 63 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)

7. DATE OF BIRTH (Month, Day, Year): Mar. 15, 1932

8. BIRTHPLACE (State or Foreign Country): Virginia

9a. FACILITY NAME (If not institution, give street and number): GOOD SAMARITAN HOSPITAL E.R.

9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY

9c. COUNTY OF DEATH: N/A

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Baltimore

10c. CITY, TOWN OR LOCATION: Hillendale

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 1620 Lyle Ct.

10f. ZIP CODE: 21234

10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 5th grade
College (1-4 or 5+):

18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Bus Driver

16b. KIND OF BUSINESS/INDUSTRY: Ferguson Charter Bus Co.

17. FATHER'S NAME (First, Middle, Last): Reston DUNCAN

18. MOTHER'S NAME (First, Middle, Maiden Surname): Malinda

19a. INFORMANT'S NAME (Type/Print): Patricia Duncan

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1620 Lyle Ct Baltimore, Maryland 21234

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Memorial Park — DATE: 7/6/95

20c. LOCATION — City or Town, State: Arbutus, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Leroy Harris

22. NAME AND ADDRESS OF FACILITY: 5240 Reisterstown Rd C.H. Tatman-Ham's F.H. Baltimore, Md 21215

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO — INSPECTION

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: J. Laron Locke M.D.

29c. LICENSE NUMBER: O.C.M.E

29d. DATE SIGNED (Month, Day, Year): JULY 2, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201

31. DATE FILED (Month, Day, Year): JUL 06 1995

32. REGISTRAR'S SIGNATURE: Julia Thacker Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RKD

95-3762-005

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-725 7/19/95 t.t

95 20387

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): TARA DULANEY			2. DATE OF DEATH (Month, Day, Year): JUNE 27 95	3. TIME OF DEATH: 8:55 AM.
4. SOCIAL SECURITY NUMBER: None	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 4 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Sept. 19/1990	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 2027 FRAMES ROAD		9b. CITY, TOWN OR LOCATION OF DEATH: DUNDALK		9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Balto.Co.	10c. CITY, TOWN OR LOCATION: Dundalk,Md.	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 2027 Frames Rd.		10f. ZIP CODE: 21222	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: ☒ 1 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): None; College (1-4 or 5+):	16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): None	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): Paul Dulaney		18. MOTHER'S NAME (First, Middle, Maiden Surname): Barbara Setters	
19a. INFORMANT'S NAME (Type/Print): Mrs.Thelma M.Browning	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1115 S.Hanover St.Balto.Md.21230		
20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery DATE 6/30/95	20c. LOCATION — City or Town, State: Balto.Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Eugene J Lastner Jr	22. NAME AND ADDRESS OF FACILITY: Balto.Md.21230 McCully Funeral Home, 130 E.Fort Ave		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SMOKE INHALATION

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☒ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): FOUND ON 6/27/95	28b. TIME OF INJURY: FOUND AT 6:45 AM	28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO
28d. DESCRIBE HOW INJURY OCCURED: UNKNOWN	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): FOUND AT HOME	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 2027 FRAMES ROAD DUNDALK, MARYLAND	

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: O.C.M.E.	29d. DATE SIGNED (Month, Day, Year): ▶ JUNE 28,1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201		
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE	

DHMH-16 Rev 1/89

RKD
95-3761-005

ITEM: 16b, PER F.H. 23 PART I, 27, 28a-f, PER MEO FILM G-725 7/18/95 t.t 95 20388

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
DAVID	WILLIAM	DOCKERY, JR	JUNE 27 95	8:55 AM

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
220-11-8412	1 [X] M 2 [ ] F	8 YRS.			July 18, 1986	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
2027 FRAMES ROAD	DUNDALK	BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Baltimore	Dundalk	1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
2027 Frames Road	21222	United States

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] YES 2 [X] NO	1 [ ] YES 2 [X] NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
3 Years		Student	~~N/A~~ DEPENDENT

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
David William Dockery, Sr.	Sharon Lee Haas

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mr. David W. Dockery, Sr.	8003 Stratman Road Dundalk, Maryland 21222

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Oak Lawn Cemetery 7/1/1995		Baltimore, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Scott P Caudon.	Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. SMOKE INHALATION	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [X] YES 2 [ ] NO	1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [X] YES 2 [ ] NO	HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [X] Could not be determined	FOUND ON 6/27/95	FOUND AT 6:45 AM	1 [ ] YES 2 [X] NO	UNKNOWN

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
FOUND AT HOME	2027 FRAMES ROAD DUNDALK, MARYLAND

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	O.C.M.E.	▶ JUNE 28, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
David R Fowler 111 Penn Street, Baltimore, Maryland 21201

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUL 06 1995	[signature]

DHMH-16 Rev 1/89

95 20389

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BARBARA ANN DORSEY				2. DATE OF DEATH (Month, Day, Year): JUNE 27, 1995	3. TIME OF DEATH: 10:55 PM
4. SOCIAL SECURITY NUMBER: 212-40-5828	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 53 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): SEPTEMBER 19, 1941	8. BIRTHPLACE (State or Foreign Country): WILKES-BARRE, PA.
9a. FACILITY NAME (If not institution, give street and number): 7000 WILLOWDALE AVENUE			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE COUNTY		9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: BALTIMORE COUNTY	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 7000 WILLOWDALE AVENUE		10f. ZIP CODE: 21206	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 1	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): KITCHEN DESIGNER	16b. KIND OF BUSINESS/INDUSTRY: KENWOOD KITCHENS		
17. FATHER'S NAME (First, Middle, Last): JOSEPH JOHN BOBROWSKI		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY MARTHA ZIMINSKI		
19a. INFORMANT'S NAME (Type/Print): JAMES E. DORSEY		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7000 WILLOWDALE AVENUE BALTIMORE, MARYLAND 21206		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): PARKWOOD CEMETERY JULY 1, 1995	DATE	20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Heather Lassahn		22. NAME AND ADDRESS OF FACILITY: LASSAHN FUNERAL HOME, INC. 7401 BELAIR ROAD BALTIMORE, MARYLAND 21236-4625		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Melanoma	7 months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Neil S. Friedman MD	29c. LICENSE NUMBER: D42178	29d. DATE SIGNED (Month, Day, Year): ▶ 6/28/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 2435 W. Belvedere Ste. 23 Baltimore, MD 21215		
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: [illegible]	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10

95 20390

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BERTHA H. DIEDRICK			2. DATE OF DEATH (Month, Day, Year): 6 12 95	3. TIME OF DEATH: 9 P M
4. SOCIAL SECURITY NUMBER: 103-52-6515	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 89 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): November 5,07	8. BIRTHPLACE (State or Foreign Country): New York
9a. FACILITY NAME (If not Institution, give street and number): 100 Rutledge Road		9b. CITY, TOWN OR LOCATION OF DEATH: Queenstown		9c. COUNTY OF DEATH: Queen Annes

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Queen Annes	10c. CITY, TOWN OR LOCATION: Queenstown	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 100 Rutledge Road		10f. ZIP CODE: 21658	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEOENT EVER IN U.S. ARMEO FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Joseph Wagner		18. MOTHER'S NAME (First, Middle, Maiden Surname): Marie	
19a. INFORMANT'S NAME (Type/Print): Melford D. Diedrick		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 100 Rutledge Road, Queenstown, MD 21658	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Neme of cemetery, cremetory or other piece)	DATE	20c. LOCATION — City or Town, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald Wade, Dir.		22. NAME AND ADDRESS OF FACILITY: State Anatomy Board 655 W. Baltimore St., Balto., MD 21201	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or reepiratory errest, shock, or heart feilure. Liet only one ceuse on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition resulting in death) →	a. Malnutrition (Refusal to Eat)	2 mo.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leeding to immediete cause. Enter UNDERLYING CAUSE (Diseese or Injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

Chronic Alzheimer's Dementia for several years

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEOICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	

27. MANNER OF OEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. OATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. OESCRIBE HOW INJURY OCCUREO
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as stated.
2 ☐ MEOICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D05754	29d. DATE SIGNED (Month, Day, Year): ▶ 6-22-95
30. NAME AND AODRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		
31. DATE FILED (Month, Day, Year): JUN 30 1995	32. REGISTRAR'S SIGNATURE	

OHMH-18 Rev 1/89

ITEM: 26. PER DR. FILM G-725 7/6/95 t.t

95 20391

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CHARLES MARKWOOD ECKMAN, JR.			2. DATE OF DEATH (Month, Day, Year): JULY 3, 1995	3. TIME OF DEATH: 7:20 A. M
4. SOCIAL SECURITY NUMBER: 217-16-0361	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 73 YRS. (If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.)	7. DATE OF BIRTH (Month, Day, Year): 09-10-1921	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): 7 GEORGIA AVENUE, N.W.		9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE		9c. COUNTY OF DEATH: ANNE ARUNDEL

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: ANNE ARUNDEL	10c. CITY, TOWN OR LOCATION: GLEN BURNIE	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 7 GEORGIA AVENUE, N.W.		10f. ZIP CODE: 21061	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO. Specify: XX	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): N/A	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): COLOR COMMENTATOR	16b. KIND OF BUSINESS/INDUSTRY: RADIO & TELEVISION SPORTS	
17. FATHER'S NAME (First, Middle, Last): CHARLES MARKWOOD ECKMAN, SR.		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARIE SCHAEFER	
19a. INFORMANT'S NAME (Type/Print): CHARLES BARRY ECKMAN		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7873 POPLAR GROVE ROAD, SEVERN, MD. 21144	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): LOUDON PARK CEMETERY DATE: 7/6/95	20c. LOCATION — City or Town, State: BALTIMORE, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Carcinoma of Colon, Metastatic	2 years
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] ND

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one). HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA. OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] ND
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D08609	29d. DATE SIGNED (Month, Day, Year): 7/3/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Arthur L. Godwin M.D., 7310 RITCHIE HIGHWAY, STE. 500, GLEN BURNIE, MD. 21061

31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: [signature]

20

DHMH-16 Rev 1/89

95 20392

Item1,g-725,7-6-95,perf.h.,dk

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDEHT'S HAME (First, Middle, Last): ~~MARY RUTH EVERHART~~ Mary Rita Everhart
2. DATE OF DEATH (Month, Day, Year): July 2 1995
3. TIME OF DEATH: 0925 M
4. SOCIAL SECURITY HUMBER: 218-12-3581
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 70 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Oct 29, 1924
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Deaton Specialty Hospital & Home, Inc.
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: NA

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Glen Burnie
10d. IHSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1568 Reinhardt Lane
10f. ZIP CODE: 21060
10g. CITIZEH OF WHAT COUHTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IH U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yee or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ HO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 — College (1-4 or 5+):
16a. DECEDEHT'S USUAL OCCUPATIOH (Give kind of work done during most of working life. Do NOT use retired.): Press Feeder
16b. KIHD OF BUSINESS/INDUSTRY: Maryland Box Co.
17. FATHER'S HAME (First, Middle, Last): John Klein
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Hoffman
19a. tNFORMANT'S HAME (Type/Print): Mr. Walter J. Everhart
19b. MAILtNG ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code): 1568 REinhardt Lane, Glen Burnie, Md. 21060
20a. METHOD OF OISPOSITIOH: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Mem. Pk. — DATE: 7/5/95
20c. LOCATION — City or Town, State: Glen Burnie, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Kevin E. Ecker
22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home of Brooklyn, 237 E. Patapsco Ave., Balto., Md. 21225

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseesea, or complications that caused tha death. Do not anter tha moda of dying, such aa cardiac or reapiratory arrest, shock, or heart failure. List only ona ceusa on eech line.

		Approximate Intarvel Between Onset and Daath
IMMEDIATE CAUSE (Final diseese or condition resulting in death) → a.	Coronary artery disease	?
DUE TO (OR AS A COHSEQUENCE OF):		
Sequentially list conditions, if any, leading to immedieta cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	congestive heart failure	?
DUE TO (OR AS A COHSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART ii. Other significant conditions contributing to death but not resulting in tha underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEOICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Hursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MAHHER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Yeer)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street end Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYIHG PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, data end place, and due to tha ceuse(s) end menner es stated.

29b. SIGHATURE AND TITLE OF CERTIFIER: (Pmchtamm)
29c. LICENSE NUMBER: D 34974
29d. DATE SIGNED (Month, Day, Year): ▶ 7-39-

30. NAME AND AOORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 5865 Robert Oliver place, Columbia, MD 21045

31. DATE FILED (Month, Day, Year): JUL 06 1995
32. REGISTRAR'S SIGNATURE: Julia Walker Randall

OHMH-16 Rev 1/89

Item1 7-6-95 FilmG725 W.H.Per F/H

95 20393

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ~~Martimus~~ Martimus Ellison
2. DATE OF DEATH (Month, Day, Year): July 03, 1995
3. TIME OF DEATH: 4:56 A M
4. SOCIAL SECURITY NUMBER: 215-70-6097
5. SEX: 1 ☑ M 2 ☐ F
6. AGE (In yrs. last birthday): 36 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): May 14, 1959
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: N/A

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: N/A
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 111 Park Ave.
10f. ZIP CODE: 21201
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☑ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): 0
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Unemployed
16b. KIND OF BUSINESS/INDUSTRY: N/A
17. FATHER'S NAME (First, Middle, Last): Jerry Ellison
18. MOTHER'S NAME (First, Middle, Maiden Surname): Lucille Lawson
19a. INFORMANT'S NAME (Type/Print): Sandra Ray
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1731 Smallwood St. Balto. Md. 21216
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest — DATE: 7/7/95
20c. LOCATION — City or Town, State: Owings Mills, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph L. Russ
22. NAME AND ADDRESS OF FACILITY: Joseph L. Russ Funeral Home 2212 W. North Ave. Balto. Md. 21216

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Sepsis	unknown
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Neurogenic Urinary Bladder	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Diabetes Mellitus	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Pulmonary Atelectasis
Pseudomembranous Enterocolitis

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☑ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: H. BHUSHAN
29c. LICENSE NUMBER: 89244
29d. DATE SIGNED (Month, Day, Year): 7/3/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Harsh Bhushan, M.D. c/o Maryland General Hospital
31. DATE FILED (Month, Day, Year): JUL 06 1995
32. REGISTRAR'S SIGNATURE: Julia Strickland-Randall

DHMH-16 Rev 1/89

95 20394

Item1,g-725,7-6-95,perf.h.,dk

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 6876, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and forwarded as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DR

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ~~JOHN A. EVANS~~ John Andrew Evans			2. DATE OF DEATH (Month, Day, Year): June 30 1995	3. TIME OF DEATH: 400 PM
4. SOCIAL SECURITY NUMBER: 216-20-8164	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 68 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): June 26, 1927	8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH: N/A

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Severna Park	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 432 Maureen Lane	10f. ZIP CODE: 21146	10g. CITIZEN OF WHAT COUNTRY?: United States	

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Pilot	16b. KIND OF BUSINESS/INDUSTRY: Maritime	
17. FATHER'S NAME (First, Middle, Last): Benjamin Evans		18. MOTHER'S NAME (First, Middle, Maiden Surname): Louise Buckley	
19a. INFORMANT'S NAME (Type/Print): Mrs. Josephine B. Evans		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 432 Maureen Lane Severna Park, Maryland 21146	

20a. METHOD OF DISPOSITION: [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Holy Rosary Cemetery	DATE: 7/3/95	20c. LOCATION — City or Town, State: Dundalk, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Charles W. Ruck		22. NAME AND ADDRESS OF FACILITY: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Renal failure	2 days
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Hepatic failure	2 days
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Metastatic lung cancer	6 mo
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [X] NO [ ] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Lee M Krug MD	29c. LICENSE NUMBER: MG302	29d. DATE SIGNED (Month, Day, Year): Jun 30, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Lee M Krug MD 110 Tower Johns Hopkins Hosp Balt. MD 21209		
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: Julia Thurlow Randall	

DHMH-16 Rev 1/89

95 20396

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Louise Boyd Flemmings			2. DATE OF DEATH (Month, Day, Year): June 28 1995	3. TIME OF DEATH: 7:40 A M
4. SOCIAL SECURITY NUMBER: 219-10-7707	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 70 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Mar. 28 1925	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): 5546 NOME AVENUE		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH: N/A

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: N/A	10c. CITY, TOWN OR LOCATION: BALTIMORE CITY	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 5546 NOME AVENUE		10f. ZIP CODE: 21215	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Patient Care Aide	16b. KIND OF BUSINESS/INDUSTRY: ROSEWOOD STATE HOSPITAL	
17. FATHER'S NAME (First, Middle, Last): SAMUEL BOYD, SR.		18. MOTHER'S NAME (First, Middle, Maiden Surname): HESTER BOYD McHENRY	
19a. INFORMANT'S NAME (Type/Print): SAMUEL B. BOYD		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1502 W. Franklin Street, Baltimore, Maryland 21223	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Druid Ridge Cemetery	DATE: 7/6	20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Diabetic mellitus	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Coronary artery disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Hypertension	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. Congestive heart failure	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: PSOM9515

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Attending Physician	29c. LICENSE NUMBER: D30115	29d. DATE SIGNED (Month, Day, Year): 6/30/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): T. Ohkokpehai, MD 2600 Liberty Heights Ave. Balt., MD 21215		
31. DATE FILED (Month, Day, Year): JUL 0 6 1995	32. REGISTRAR'S SIGNATURE: [signature] Theodora Randall	

DHMH-18 Rev 1/89

95 20395

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ress Elkins			2. DATE OF DEATH (Month, Day, Year): July 1, 1995	3. TIME OF DEATH: 5:30P M
4. SOCIAL SECURITY NUMBER: 421-16-8261	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 72 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Jan. 11, 1923	8. BIRTHPLACE (State or Foreign Country): Alabama
9a. FACILITY NAME (If not institution, give street and number): Johns Hopkins Bayview Geriatric Ctr.		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH: N/A

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Dundalk	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 7703 Wynbrook Road		10f. ZIP CODE: 21224	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years; College (1-4 or 5+):	16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Tool & Die	16b. KIND OF BUSINESS/INDUSTRY: Steel Industry	
17. FATNER'S NAME (First, Middle, Last): Ress E. Elkins		18. MOTNER'S NAME (First, Middle, Maiden Surname): Susie Cowan	
19a. INFORMANT'S NAME (Type/Print): Vevette Elkins		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7703 Wynbrook Road Baltimore, Maryland 21224	
20a. METNOD OF DISPOSITION: [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith Cem. DATE: 7/5/95		20c. LOCATION — City or Town, State: Rossville, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. cardiac arrhythmia	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. coronary artery disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28b. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Jeremy Walston	29c. LICENSE NUMBER: D38849	29d. DATE SIGNED (Month, Day, Year): 7/2/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print): Jeremy Walston Johns Hopkins Bayview 4940 Eastern Ave. Baltimore Maryland21224

31. DATE FILED (Month, Day, Year): JUL 06 1995	REGISTRAR SIGNATURE: [signature]

OHMH-16 Rev 1/89

95 20397

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Benjamin Franklin Fuller				2. DATE OF DEATH (Month, Day, Year): 7 2 95	3. TIME OF DEATH: 4:33 P M
4. SOCIAL SECURITY NUMBER: 239-20-1714	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Dec. 11 1918	8. BIRTHPLACE (State or Foreign Country): North Carolina
9a. FACILITY NAME (If not institution, give street and number): 669 Kittendale Circle		9b. CITY, TOWN OR LOCATION OF DEATH: N/A		9c. COUNTY OF DEATH: Baltimore Co.	

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE CO.	10c. CITY, TOWN OR LOCATION: N/A	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 669 Kittendale Circle		10f. ZIP CODE: 21220	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO; IF YES, GIVE WAR OR DATES: 1946 to 1947	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6th grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Tractor Trailer Driver	16b. KIND OF BUSINESS/INDUSTRY: UNKNOWN	
17. FATHER'S NAME (First, Middle, Last): William Fuller		18. MOTHER'S NAME (First, Middle, Maiden Surname): Emma Fuller	
19a. INFORMANT'S NAME (Type/Print): Sheila Lee Stoddart		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 669 Kittendale Circle, Baltimore, Maryland 21220	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Crownsville Veteran Cem. DATE: 7/10	20c. LOCATION — City or Town, State: Crownsville, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: WILLIAM C. BROWN COMMUNITY F/H 1206 W. North Avenue		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Prostate Cancer	7 yr
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.: NA

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)			
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): NA	28b. TIME OF INJURY: NA M	28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO	28d. DESCRIBE HOW INJURY OCCURED: NA
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): NA			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D44604	29d. DATE SIGNED (Month, Day, Year): 7/3/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 9000 Frankl Sq Dr Baltimor Michael Sutor Maryland 21237

31. DATE FILED (Month, Day, Year): JUL 0 6 1995	32. REGISTRAR'S SIGNATURE: Julia Shuldson Randall

DHMH-16 Rev 1/89

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95 20398

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Erma Jewell Furgason			2. DATE OF DEATH (Month, Day, Year): July 1 1995	3. TIME OF DEATH: 7:00PM M
4. SOCIAL SECURITY NUMBER: 482-22-0755	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 85 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): July 311909	8. BIRTHPLACE (State or Foreign Country): Missouri
8a. FACILITY NAME (If not institution, give street and number): Elternhaus Nursing & Rehabilitation		9b. CITY, TOWN OR LOCATION OF DEATH: Dayton	9c. COUNTY OF DEATH: Howard	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Howard	10c. CITY, TOWN OR LOCATION: Dayton	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 13902 Hallowell Ct.		10f. ZIP CODE: 21036	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th; College (1-4 or 8 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Domestic	
17. FATHER'S NAME (First, Middle, Last): Willie Mitchell		18. MOTHER'S NAME (First, Middle, Maiden Surname): Fannie Horton	
19a. INFORMANT'S NAME (Type/Print): Dorothy Bascom		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13902 Hallowell Ct. Dayton, Md. 21036	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Unionville Cemetery	DATE	20c. LOCATION — City or Town, State: Unionville, Mo.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: Slack Funeral Home, P.A. Ellicott City, Md. 21043	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	ATHEROSCLEROSIS	YRS
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	CONGESTIVE HEART FAILURE	YRS
DUE TO (OR AS A CONSEQUENCE OF):		
c.	DEMENTIA	YRS
DUE TO (OR AS A CONSEQUENCE OF):		
d.	HYPOTENSION	YRS

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PARKINSONS

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D31172	29d. DATE SIGNED (Month, Day, Year): ▶ 7/3/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Hal Okun MD 3460 Ellicott Center Dr 103 Ellicott City MD 21043		
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: [signature]	

DHMH-16 Rev 1/89

95 20399

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Luke Fisher				2. DATE OF DEATH (Month, Day, Year): June 20, 1995	3. TIME OF DEATH: 8:45 A M
4. SOCIAL SECURITY NUMBER: 219-03-0924	5. SEX: 1 [X] M 2 [ ] F	6. AGE (in yrs. last birthday): 74 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): June 3, 21	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Levendale Hospital Center			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: 2525 W. Belevdere St.		10f. ZIP CODE: 21215	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Plumber's Asst.	16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): Luke A. Fisher		18. MOTHER'S NAME (First, Middle, Maiden Surname): Myrtle Harris	
19a. INFORMANT'S NAME (Type/Print): Doris Leimbach		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4102 Kinsway, Baltimore, MD 21206	

20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald Wade, Dir. ▶ Ronald Wade	22. NAME AND ADDRESS OF FACILITY: State Anatomy Board 655 W. Baltimore St., Balto., MD 21201		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. acute Cardio - pulmonary arrest DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. atherosclerotic coronary artery disease DUE TO (OR AS A CONSEQUENCE OF):	
	c. chronic obstructive pulmonary disease DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

s/p cerebrovascular accident
anemia multi-infarct dementia

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [✓]

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Consult Mranz MD	29c. LICENSE NUMBER: D 44907	29d. DATE SIGNED (Month, Day, Year) ▶ 6/20/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CONSULTANT 2434 W. Belvedere Ave Balto MD 21217

31. DATE FILED (Month, Day, Year): JUN 30 1995	32. REGISTRAR'S SIGNATURE: Kathleen Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 20400

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ARTHUR FRANCIS GOHO.			2. DATE OF DEATH (Month, Day, Year): 07 04 95	3. TIME OF DEATH: 10:10A M
4. SOCIAL SECURITY NUMBER: 176-03-7731	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 85 YRS. (If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.)	7. DATE OF BIRTH (Month, Day, Year): JUNE 28, 1909	8. BIRTHPLACE (State or Foreign Country): PHILADELPHIA, PA
9a. FACILITY NAME (If not institution, give street and number): CHARLESTOWN CARE CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: CATONSVILLE	9c. COUNTY OF DEATH: BALTIMORE	
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: CATONSVILLE	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO	
10e. STREET AND NUMBER: 707 MAIDEN CHOICE LANE CC-225-SOUTH		10f. ZIP CODE: 21228	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12):	College (1-4 or 5+): 4 YRS	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ENGINEER	16b. KIND OF BUSINESS/INDUSTRY: CIVIL SERVICE	
17. FATHER'S NAME (First, Middle, Last): FRANCIS GOHO		18. MOTHER'S NAME (First, Middle, Maiden Surname): HELLEN ANN LYNCH		
19a. INFORMANT'S NAME (Type/Print): MRS. BARBARA G. LAZZATI		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13710 MANDA MILL LANE - PHOENIX, MD 21131		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): NEW CATHEDERAL CEMETERY DATE: 7/8	20c. LOCATION — City or Town, State: BALTIMORE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jackie D. Shannon		22. NAME AND ADDRESS OF FACILITY: HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ISCHEMIC LEFT LEG	4 DAYS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. PERIPHERAL VASCULAR DISEASE	4 YEARS
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

@ PARIETAL STROKE

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [✓] NO [ ] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [✓] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [✓] NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [✓] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Matt J. N... M.D.	29c. LICENSE NUMBER: D44748	29d. DATE SIGNED (Month, Day, Year): 7/7/5/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 711 MAIDEN CHOICE LANE CATONSVILLE MD 21228.		
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: Julie [illegible] Reed	

DHMH-16 Rev 1/89

4

95 20401

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MAE E GREENFIELD			2. DATE OF DEATH: MONTH JUL. DAY 2nd YEAR 1995	3. TIME OF DEATH: 11:47 PM M
4. SOCIAL SECURITY NUMBER: 212-22-7421	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 68 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Dec. 3, 1926	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL ASSOCIATION		9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE		9c. COUNTY OF DEATH: A.A. COUNTY
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Pasadena		10d. INSIDE CITY LIMITS? XX 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 864 North Shore Drive		10f. ZIP CODE: 21122		10g. CITIZEN OF WHAT COUNTRY? United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker		16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Richard M. Ecker, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret Elizabeth Grimes		
19a. INFORMANT'S NAME (Type/Print): Mr. Anthony F. Greenfield, Jr.	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 19 Tollgate Road Owings Mills, Maryland 21117			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery — DATE: 7/6/95	20c. LOCATION — City or Town, State: Baltimore, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Valerie L. Polymate	22. NAME AND ADDRESS OF FACILITY: Mc Cully Funeral Home of Pasadena 3204 Mountain Road Pasadena, MD. 21122			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Coronary Artery Disease — DUE TO (OR AS A CONSEQUENCE OF):	10 years
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. — DUE TO (OR AS A CONSEQUENCE OF):	
	c. — DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☒ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Paul J. Young-Hyman

29c. LICENSE NUMBER: MD-6664

29d. DATE SIGNED (Month, Day, Year): ▶ 7/7/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PAUL J. YOUNG-HYMAN, M.D. /1600 CRAIN HWY, SW #601/GLEN BURNIE, MD 21061

31. DATE FILED (Month, Day, Year): JUL 06 1995

32. REGISTRAR'S SIGNATURE: Julia Woodward Smith

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DHMH-18 Rev 1/89

95 20402

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Gregory Marshall GLENN		2. DATE OF DEATH: MONTH July 2 DAY 1995	3. TIME OF DEATH: 2:05 a. M
4. SOCIAL SECURITY NUMBER: 215-60-1579	5. SEX: 1 ☑ M 2 ☐ F	6. AGE (In yrs. last birthday): 42 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): JUN 12 1953
8. BIRTHPLACE (State or Foreign Country): MARYLAND			
9a. FACILITY NAME (If not institution, give street and number): Doctors Community Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Lanham	9c. COUNTY OF DEATH: Prince George's	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: PRINCE GEORGE'S	10c. CITY, TOWN OR LOCATION: LANHAM	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☑ NO
10e. STREET AND NUMBER: 3200 Glen Ave.	10f. ZIP CODE: 20706	10g. CITIZEN OF WHAT COUNTRY? U.S.A	
11. MARITAL STATUS: 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☑ YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): OPERATOR	16b. KIND OF BUSINESS/INDUSTRY: SOCIAL SECURITY
17. FATHER'S NAME (First, Middle, Last): THEODORE GLENN	18. MOTHER'S NAME (First, Middle, Maiden Surname): ETHEL GLENN	
19a. INFORMANT'S NAME (Type/Print): THEODORE GLENN	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 822 S. Carr Ave. Balt. MD. 21229	

20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE: Carter-Jones Funeral Home VA	20c. LOCATION — City or Town, State: Hyattsville MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: Gary P. March Funeral Home VA 2700 Fred Hill Ter Balt. MD. 21229	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Hypertensive cardiovascular disease	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): b.	
	DUE TO (OR AS A CONSEQUENCE OF): c.	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Apnea bipolar

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☑

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☑ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☑ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Augusto P. Rodriguez MD	29c. LICENSE NUMBER: D21230	29d. DATE SIGNED (Month, Day, Year): July 2, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Augusto P. Rodriguez MD, 5009 Rayburn Ct. Cheltenham MD 20623		
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: Julia Mercer Randall	

OHMH-18 Rev 1/89

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95-3788-510
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FilmG, 725, item 31, 7/6/95,cyw, per f.h.

95 20403

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LETHA MARIA ~~JOLEBIWSKI~~ GOLEBIWSKI			2. DATE OF DEATH (Month, Day, Year): JUNE 28, 1995	3. TIME OF DEATH: 5:17 P M
4. SOCIAL SECURITY NUMBER: 219-10-5201	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): June 27, 1921	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): BAYVIEW MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH: N/A

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Edgemere	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 2616 Masseth Avenue		10f. ZIP CODE: 21219	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Ward Clair Lydic		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ina Marria Inez	
19a. INFORMANT'S NAME (Type/Print): Dolores J. Marcim		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8348 Williamstown Drive Millersville, MD 21108	

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Sacred Ht. of Mary Cem. DATE: 7/7/95	20c. LOCATION — City or Town, State: Dundalk, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Gregory E. Ruck		22. NAME AND ADDRESS OF FACILITY: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic Cardiovascular Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	26a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY M	26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	26d. DESCRIBE HOW INJURY OCCURED
	26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: O.C.M.E.	29d. DATE SIGNED (Month, Day, Year): JUNE 30, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ann Dixon M.D.	111 Penn Street, Baltimore, Maryland 21201	
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: Julia Strecker-Randall	

DHMH-16 Rev 1/89

and Baltimore

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Years	Homemaker	Own Home
ward Clair Lydic		Ina Morris Iner
Dolores J. Marcum	8348 Williamstown Drive Millersville, M	

x

Sacred Ht. of Mary Cem. 7/1/95 Dundalk

Duda-Ruck Funeral Home
7922 Wise Ave. Dund

95 20404

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEDENT'S NAME (First, Middle, Last): HELEN MAY GROFT			2. DATE OF DEATH (Month, Day, Year): 6 29 95	3. TIME OF DEATH: 7:05 AM
4. SOCIAL SECURITY NUMBER: 213-20-5505	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 91 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 9/5/03	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Good Samaritan Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH: N/A
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Rosedale		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 6406 Martinique Road		10f. ZIP CODE: 21237		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 years — College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Chocolate Dipper	16b. KIND OF BUSINESS/INDUSTRY: Candy Co.		
17. FATHER'S NAME (First, Middle, Last): William Shaffer		18. MOTHER'S NAME (First, Middle, Maiden Surname): Gertrude Buchman		
19a. INFORMANT'S NAME (Type/Print): Ruth Fahnestock	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6406 Martinique Road Rosedale, MD 21237			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Westminster Cemetery — DATE: 7/3/95	20c. LOCATION — City or Town, State: Westminster, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶	22. NAME AND ADDRESS OF FACILITY: Johnson Funeral Home 8521 Loch Raven Blvd. Towson, MD 21286			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. BILATERAL PNEUMONIA	3 DAYS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. E.COLI SEPTICEMIA	ONE WEEK
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PRE GANGRENOUS LEFT LEG

DEMENTIA

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) — 28b. TIME OF INJURY — 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO — 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: (P-07618)	29c. LICENSE NUMBER: P-07618	29d. DATE SIGNED (Month, Day, Year) ▶ 6/29/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): KOFI BOAITEY MD 5601 LOCH RAVEN BLVD BALTO MD 21239		GOOD SAMARITAN HOSP
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall	

DHMH-16 Rev 1/89

95 20405

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Wilson Albert GRAY			2. DATE OF DEATH (Month, Day, Year): June 19 1995	3. TIME OF DEATH: 5:21 a M
4. SOCIAL SECURITY NUMBER: 219-40-9784	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 51 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): July 8,1943	8. BIRTHPLACE (State or Foreign Country)
9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore	9c. COUNTY OF DEATH: Baltimore	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: 388 Langley Road		10f. ZIP CODE: 21221	10g. CITIZEN OF WHAT COUNTRY?

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NAME (First, Middle, Maiden Surname)	
19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) in state	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald Wade, Dir. Ronald Wade	22. NAME AND ADDRESS OF FACILITY: State Anatomy Board 655 W. Baltimore St., Balto., MD 21201		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Gangrenous bowel	72 hours
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Bowel obstruction	72 hours
DUE TO (OR AS A CONSEQUENCE OF):		
	c. Possible superior mesenteric artery embolus	72 hours
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [X] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28d. DESCRIBE HOW INJURY OCCURED	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Richard Wagner	29c. LICENSE NUMBER: AT743946	29d. DATE SIGNED (Month, Day, Year): 6-19-95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Richard Wagner M.D. 9000 Franklin Square Drive Baltimore Md. 21237-3998

31. DATE FILED (Month, Day, Year): JUN 30 1995	32. REGISTRAR'S SIGNATURE: [illegible] Randall

DHMH-18 Rev 1/89

FilmG, 725, item #1, 7/6/95,cyw, per f.h.

95 20406

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ~~MICHAEL HICKS~~ MICHAEL KENNETH HICKS				2. DATE OF DEATH (Month, Day, Year): July 1, 1995	3. TIME OF DEATH: 09:30 AM
4. SOCIAL SECURITY NUMBER: 212-86-0972	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 30 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Feb. 21 1965	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): LIBERTY MEDICAL CENTER			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH: N/A

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: n/a	10c. CITY, TOWN OR LOCATION: BALTIMORE CITY	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3409 ROSEDALE ROAD		10f. ZIP CODE: 21215	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): STOCK CLERK	16b. KIND OF BUSINESS/INDUSTRY: UNKNOWN
17. FATHER'S NAME (First, Middle, Last): ERVIN SMITH	18. MOTHER'S NAME (First, Middle, Maiden Surname): JOYCE BRENDA HICKS	
19a. INFORMANT'S NAME (Type/Print): CLIFFIE JOHNSON	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3409 Rosedale Road, Baltimore, Maryland 21215	

20. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Zion Cemetery	DATE: 7/6	20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Septic Shock	7 Days
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Bacterial Endocarditis	2-3 WEEKS
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Intravenous drug abuse	10 years.
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [ ] NO	1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [X]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature], MD House physician	29c. LICENSE NUMBER: D45148	29d. DATE SIGNED (Month, Day, Year): July 1, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ricardo Osorno Liberty Medical Center			
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: [signature]		

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 Rev 1/89

95 20407

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): KARL WILLIAM HARTIG			2. DATE OF DEATH (Month, Day, Year): June 30, 1995	3. TIME OF DEATH: 11:42 A.M
4. SOCIAL SECURITY NUMBER: 212-05-5224	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 80 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Feb. 25, 1915	8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): Union Memorial Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City	9c. COUNTY OF DEATH: N/A

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: N/A	10c. CITY, TOWN OR LOCATION: Baltimore City	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 912 Chestnut Hill Avenue		10f. ZIP CODE: 21218	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES: X	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: X	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12):	College (1-4 or 5+): 2 yrs	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Construction Supervisor	16b. KIND OF BUSINESS/INDUSTRY: Gas & Electric Utilities

17. FATHER'S NAME (First, Middle, Last): August Hartig	18. MOTHER'S NAME (First, Middle, Maiden Surname): Adelaide Anna vonHohenthal
19a. INFORMANT'S NAME (Type/Print): Mrs. Margaret E. Hartig	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 912 Chestnut Hill Avenue, Baltimore, Maryland 21218

20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cemetery	DATE: 7/3	20c. LOCATION — City or Town, State: Parkville, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Martin D. Lawson Martin D. Lawson	22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home, Inc. 6500 York Road, Baltimore, Maryland 21212

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Sepsis	19 days
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Disseminated intravascular coagulation	6 hours
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Gastrojejunostomy	19 days
DUE TO (OR AS A CONSEQUENCE OF):		
d.	Pancreatic cancer.	6 months

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal insufficiency
Respiratory failure

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [✓] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [✓] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [✓] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M. Tuncbilek, M.D.	29c. LICENSE NUMBER: AT24389 46	29d. DATE SIGNED (Month, Day, Year): ▶ 7/5/95.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Meltem Tuncbilek, M.D. Union Memorial Hospital, Baltimore, MD 21218

31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: Julia Stricker Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10

95 20408

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARY ELIZABETH HESS
2. DATE OF DEATH (Month, Day, Year): July 5, 1995
3. TIME OF DEATH: 9:50P M
4. SOCIAL SECURITY NUMBER: 215-03-1425
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 100 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): December 17, 1894
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Perring Parkway Meridian
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1801 Wentworth Road
10f. ZIP CODE: 21234
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 / College (1-4 or 5 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Factory Worker
16b. KIND OF BUSINESS/INDUSTRY: Netting Manufacturing
17. FATHER'S NAME (First, Middle, Last): John Hess
18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine Heilein
19a. INFORMANT'S NAME (Type/Print): Albert M. Antlitz
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5 Concord Place Havre de Grace Maryland 21078
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Holy Cross Cemetery DATE 7/8
20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dennis Stephen Kenakis
22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pneumonia	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. COPD	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerotic cardiovascular disease

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: D-08358
29d. DATE SIGNED (Month, Day, Year): ▶ July 6, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Gracito Patricio 703 South Clinton St. Baltimore, MAryland 21224
31. DATE FILED (Month, Day, Year): JUL 0 6 1995
32. REGISTRAR'S SIGNATURE: Julia Henderson Randall

DHMH-18 Rev 1/89

95 20409

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Joseph M. Henry			2. DATE OF DEATH (Month, Day, Year): June 29, 1995	3. TIME OF DEATH: 9:00 P.M
4. SOCIAL SECURITY NUMBER: 215-07-9607	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 79 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): June 9, 1916	8. BIRTHPLACE (State or Foreign Country): New York
9a. FACILITY NAME (If not institution, give street and number): Meridian Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: Catonsville		9c. COUNTY OF DEATH: Balto.Co.Md.

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: none	10c. CITY, TOWN OR LOCATION: Balto.City,Md.	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 114 Burnett St.		10f. ZIP CODE: 21230	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: W.W.2	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th.Grade; College (1-4 or 5+): none	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Warehouseman	16b. KIND OF BUSINESS/INDUSTRY: Cold Storage Warehouse	
17. FATHER'S NAME (First, Middle, Last): John Henry		18. MOTHER'S NAME (First, Middle, Maiden Surname): Lillian M. Smith	
19a. INFORMANT'S NAME (Type/Print): Mrs.Lillian M.Eder		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 126 W.Clement St.Balto.Md. 21230	

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery	DATE: 7/3/95	20c. LOCATION — City or Town, State: Balto.Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: Balto.Md.21230 McCully Funeral Home, 130 E.Fort Ave	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CARCINOMA PROSTATE	2 Yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. RENAL FAILURE	1 Yr
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D1566O	29d. DATE SIGNED (Month, Day, Year): 7/3/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARC S. POSNER MD 1147 S. HANOVER ST		
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: [signature] Gladys Randall	

DHMH-18 Rev 1/89

95 20410

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Elizabeth F. Hasselbarth				2. DATE OF DEATH (Month, Day, Year): June 30, 1995	3. TIME OF DEATH: 9:47 PM M
4. SOCIAL SECURITY NUMBER: 212-38-0249	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 82 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): March 31, 1913	8. BIRTHPLACE (State or Foreign Country): North Carolina
9a. FACILITY NAME (If not institution, give street and number): 6825 Campfield Rd. 6D			9b. CITY, TOWN OR LOCATION OF DEATH: Lochearn		9c. COUNTY OF DEATH: Baltimore County

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore Co.	10c. CITY, TOWN OR LOCATION: Lochearn	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 6825 Campfield Rd. 6D		10f. ZIP CODE: 21207	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 5+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Registered Nurse	16b. KIND OF BUSINESS/INDUSTRY: Hospital

17. FATHER'S NAME (First, Middle, Last): Louie Nash	18. MOTHER'S NAME (First, Middle, Maiden Surname): Mollie Faris
19a. INFORMANT'S NAME (Type/Print): Mr. Edwin Sofsky	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1902 Larch Ct. Edgewood, MD 21040

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Woodlawn Cemetery	DATE: 7-5	20c. LOCATION — City or Town, State: Woodlawn, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John K Aycock Jr	22. NAME AND ADDRESS OF FACILITY: Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. metastatic liver cancer	Months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

A Terminal

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☑ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD	29c. LICENSE NUMBER: D15872	29d. DATE SIGNED (Month, Day, Year): ▶ July 3 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): HAROLD BOBMAN 7224 PARK Heights 21215

31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: John [illegible]

DHMH-18 Rev 1/89

Item1 7-6-95 FilmG725 W.H.Per F/H

95 20411

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ~~Mary Haggerty~~ Mary Margaret Haggerty			2. DATE OF DEATH (Month, Day, Year): July 4, 1995	3. TIME OF DEATH: 4:10 P M
4. SOCIAL SECURITY NUMBER: 220-05-8938	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 04-04-1919	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): North Arundel Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Glen Burnie		9c. COUNTY OF DEATH: Ann Arundel

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: ANNE ARUNDEL	10c. CITY, TOWN OR LOCATION: SEVERNA PARK	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 298 TOLSTOY LANE		10f. ZIP CODE: 21146	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): N/A	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SECRETARY	16b. KIND OF BUSINESS/INDUSTRY: STATE FARM INSURANCE	
17. FATHER'S NAME (First, Middle, Last): WILLIAM J. QUINN		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARGARET SPANHIEMER	
19a. INFORMANT'S NAME (Type/Print): MARY LOU ACOSTA		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 298 TOLSTOY LANE, SEVERNA PARK, MARYLAND 21146	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): GLEN HAVEN MEMORIAL PARK DATE: 7/8/95	20c. LOCATION — City or Town, State: GLEN BURNIE, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶		22. NAME AND ADDRESS OF FACILITY: SINGLETON FUNERAL HOME, 1 SECOND AVE., S.W., GLEN BURNIE, MD. 21061	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Severe Metabolic Encephalopathy	4 weeks
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Coronary Artery Bypass, Ischemic Cardiomyopathy,

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ ~~NO~~	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ ~~NO~~	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ ~~NO~~	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: MD-6667	29d. DATE SIGNED (Month, Day, Year) ▶ 7/7/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 1600 Crain Highway Glen Burnie MD 21061		
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

95 20412

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Elmer D. HEPBURN			2. DATE OF DEATH (Month, Day, Year): July 5 1995	3. TIME OF DEATH: 7:35 A M
4. SOCIAL SECURITY NUMBER: 146-18-9227	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 71 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): July 24, 1923	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1822 Kitty Hawk Rd.	10f. ZIP CODE: 21221	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): N/A	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Maintenance Worker	16b. KIND OF BUSINESS/INDUSTRY: Apartment Complex	
17. FATHER'S NAME (First, Middle, Last): Elmer Hepburn		18. MOTHER'S NAME (First, Middle, Maiden Surname): Matilda Ethel Aikins	
19a. INFORMANT'S NAME (Type/Print): Mrs. Agnes I. Hepburn		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1822 KItty Hawk Rd. Balto.,Md. 21221	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens Of Faith Cem.	DATE: 7/8	20c. LOCATION — City or Town, State: Balto.Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jay D Smith		22. NAME AND ADDRESS OF FACILITY: Hartley Miller Funeral Home 7527 Hanford Rd. Balto.Md. 21234	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Metastatic lung cancer	6 years
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.		
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [X] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: RD 1926	29d. DATE SIGNED (Month, Day, Year): July 5, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Sheena Antonio, M.D. 9000Franklin Square Drive Baltimore, MD 21237		
31. DATE FILED (Month, Day, Year): JUL 0 6 1995	32. REGISTRAR'S SIGNATURE: Julia Chandler Randall	

DHMH-16 Rev 1/89

6+1

95 20413

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MATTHEW HEYDRICK
2. DATE OF DEATH: MONTH JUL DAY 2 YEAR 1995
3. TIME OF DEATH: 4.10 PM M
4. SOCIAL SECURITY NUMBER: N/A
5. SEX: 1 X M 2 ☐ F
6. AGE (In yrs. last birthday): N/A YRS. IF UNDER 1 YEAR: MONTHS DAYS 5 IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): June 27, 1995
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Howard County General Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Columbia
9c. COUNTY OF DEATH: Howard

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Howard
10c. CITY, TOWN OR LOCATION: Columbia
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO
10e. STREET AND NUMBER: 6022 Cedar Wood Drive
10f. ZIP CODE: 21044
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): N/A
16b. KIND OF BUSINESS/INDUSTRY: N/A
17. FATHER'S NAME (First, Middle, Last): David Scott Heydrick
18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie Elizabeth Cole
19a. INFORMANT'S NAME (Type/Print): David Scott Heydrick
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6022 Cedar Wood Drive Columbia, Maryland 21044
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory DATE July 5, 1995
20c. LOCATION — City or Town, State: Catonsville, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: Leroy M. & Russell C. Witzke Funeral Homes 1630 Edmondson Avenue Catonsville, Maryland 21228

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CONGESTIVE HEART FAILURE	1 DAY
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. TRISOMY 18	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

28. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

26a. DATE OF INJURY (Month, Day, Year): NA
26b. TIME OF INJURY: NA M
26c. INJURY AT WORK? NA 1 ☐ YES 2 ☐ NO
26d. DESCRIBE HOW INJURY OCCURED: NA
26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): NA
26f. LOCATION (Street and Number or Rural Route Number, City or Town, State): NA

29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: NRAgwuna MD
29c. LICENSE NUMBER: D 44795
29d. DATE SIGNED (Month, Day, Year): JUL 2 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): NGOZI RUTH AGWUNA SPECIAL CARE NURSERY, HOWARD COUNTY GENERAL HOSP
31. DATE FILED (Month, Day, Year): JUL 06 1995
32. REGISTRAR'S SIGNATURE: Julia [illegible]

DHMH-18 Rev 1/89

95 20414

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): FRANK C. HRUZ			2. DATE OF DEATH (Month, Day, Year): JULY 4, 1995	3. TIME OF DEATH: 9:25 P. M
4. SOCIAL SECURITY NUMBER: 220-01-4659	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 75 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 8-21-1919	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Fort Howard VA Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH: Fort Howard	9c. COUNTY OF DEATH: Baltimore	
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Dundalk	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO	
10e. STREET AND NUMBER: 95 Willow Spring Rd.		10f. ZIP CODE: 21222	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Welder	16b. KIND OF BUSINESS/INDUSTRY: Beth-Steel Shipyard		
17. FATHER'S NAME (First, Middle, Last): John Hruz		18. MOTHER'S NAME (First, Middle, Maiden Surname): Treresa Chechotorisky		
19a. INFORMANT'S NAME (Type/Print): Robert D. Hruz		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 103 Drew Ct. Joppa, Md 21085		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): St. Stanislaus Cemete	DATE: 7-7	20c. LOCATION — City or Town, State: Baltimore, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Anthony Colt Connelly		22. NAME AND ADDRESS OF FACILITY: Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such es cerdiec or respiratory srrest, shock, or heart failure. List only one ceuse on each line.

Approximete Intervel Between Onset snd Death

IMMEDIATE CAUSE (Finel disesse or conditipn resulting in deeth) →
a. CARCINOMA OF LUNG
DUE TO (OR AS A CONSEQUENCE OF):

Sequentislly list conditipns, if eny, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury thst initieted events resulting in deeth) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [X] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(s) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Chandrakala Raja
29c. LICENSE NUMBER: D 45244
29d. DATE SIGNED (Month, Day, Year): ▶ 7/5/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CHANDRAKALA, RAJA, M.D., VA MEDICAL CENTER, FORT HOWARD, MD 21052

31. DATE FILED (Month, Day, Year): JUL 06 1995
32. REGISTRAR'S SIGNATURE: Julia Chandrakala

DHMH-16 Rev 1/89

95 20415

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CHARLES F HARDEN, JR.			2. DATE OF DEATH (Month, Day, Year): July 3 1995	3. TIME OF DEATH: 3:00pm M
4. SOCIAL SECURITY NUMBER: 217-05-8964	5. SEX: 1 ☑ M 2 ☐ F	6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): January 26, 1919	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 5811 Oklahoma Road		9b. CITY, TOWN OR LOCATION OF DEATH: Sykesville	9c. COUNTY OF DEATH: Carroll County	
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Carroll County	10c. CITY, TOWN OR LOCATION: Sykesville	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO	
10e. STREET AND NUMBER: 5811 Oklahoma Road		10f. ZIP CODE: 21784	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Machinest	16b. KIND OF BUSINESS/INDUSTRY: Maryland Cup Corp.		
17. FATNER'S NAME (First, Middle, Last): Charles F. Harden, Sr.		18. MOTNER'S NAME (First, Middle, Maiden Surname): Elva Kraft		
19a. INFORMANT'S NAME (Type/Print): Mrs. Helen B. Harden		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5811 Oklahoma Road Sykesville, MD 21784		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Carroll Cremation Service	DATE: 7/5/95	20c. LOCATION — City or Town, State: Hampstead, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Brian L. Haight		22. NAME AND ADDRESS OF FACILITY: HAIGHT FUNERAL HOME (P.O. Box 195) Sykesville, MD 21784 (410)-795-1400		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic Cerebrovascular Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Chronic Obstructive Lung Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Hypertension	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☑

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Patrick A Turners MD	29c. LICENSE NUMBER: D20806	29d. DATE SIGNED (Month, Day, Year) ▶ 7/3/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PATRICK A TURNER, MD 1425 Liberty Rd Eldersburg, MD 21784

31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: Jean Marchese Randall

541

DHMH-16 Rev 1/89

95 20416

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Theodore G. Huettel			2. DATE OF DEATH (Month, Day, Year): June 30, 1995	3. TIME OF DEATH: 5;45 P.M
4. SOCIAL SECURITY NUMBER: 215 01 2295	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 85 YRS. (If under 1 year: Months; If under 24 hrs.: Days, Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): Jan. 21, 1910	8. BIRTHPLACE (State or Foreign Country): Germany
9a. FACILITY NAME (If not institution, give street and number): 2209 Harvest Farm Rd.		9b. CITY, TOWN OR LOCATION OF DEATH: Sykesville		9c. COUNTY OF DEATH: Carroll
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY: Howard	10c. CITY, TOWN OR LOCATION: Ellicott City		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 2605 N. Rogers Ave.		10f. ZIP CODE: 21043		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): High School; College (1-4 or 5+): 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Warehouse MaNAGER		16b. KIND OF BUSINESS/INDUSTRY: Hajoca Co.
17. FATHER'S NAME (First, Middle, Last): Theodore Huettel			18. MOTHER'S NAME (First, Middle, Maiden Surname): Elsa Unk.	
19a. INFORMANT'S NAME (Type/Print): Richard B. Huettel		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2209 Harvest Farm Rd. Sykesville, Md. 21784		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Carroll Cremation Service DATE: 7/1/95		20c. LOCATION — City or Town, State: Hampastead Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Harry W. Haight		22. NAME AND ADDRESS OF FACILITY: Haight Funeral Home P.O.Box 195 Sykesville, Md. 21784		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	LUNG CARCINOMA	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	CIGARETTE SMOKING	
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC OBSTRUCTIVE LUNG DISEASE

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [X] NO [ ] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Jay Gerstenblith, M.D.	D 20724	▶ 7/1/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JAY GERSTENBLITH, M.D. 3455 WILKENS AVE. BALTO, MD 21229

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUL 06 1995	[signature]

DHMH-16 Rev 1/89

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95 20417

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Jesse Moreman Herndon, Jr.				2. DATE OF DEATH: MONTH 07 DAY 03 YEAR 95	3. TIME OF DEATH: 4 45 pM
4. SOCIAL SECURITY NUMBER: 336-10-5253	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 82 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Jan. 9, 1913	8. BIRTHPLACE (State or Foreign Country): Kentucky
9a. FACILITY NAME (If not institution, give street and number): Greater Laurel Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Laurel		9c. COUNTY OF DEATH: Prince Georges

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Howard County	10c. CITY, TOWN OR LOCATION: Columbia	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 6336 Cedar Lane		10f. ZIP CODE: 21044	10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. OECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4	16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): General Manager	16b. KIND OF BUSINESS/INDUSTRY: Chemical Plant
17. FATHER'S NAME (First, Middle, Last): Jesse Moreman Herndon, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Nell Washington Lewis	
19a. INFORMANT'S NAME (Type/Print): Mr. Jesse Herndon, III		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5870 Springmount Ct. Eldersburg, MD 21784	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place): Carroll Cremation Serv. DATE: 7/5/95	20c. LOCATION — City or Town, State: Hampstead, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Brian L. Haight		22. NAME AND ADDRESS OF FACILITY: HAIGHT FUNERAL HOME (P.O. Box 195) Sykesville, MD 21784 (410)-795-1400	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Congestive Heart Failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Acute Myocardial Infarction	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic Obstructive Pulmonary Disease
Renal Insufficiency

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH ☐ YES ☐ NO ☐ UNCERTAIN

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M.D.	29c. LICENSE NUMBER: D 24721	29d. DATE SIGNED (Month, Day, Year): ▶ 7/3/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): STEB SAMIR 14800, 4th St. LAUREL, MD 20707		
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: [signature]	

DHMH-16 Rev 1/89

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95 20418

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Anne R. IRETON
2. DATE OF DEATH (Month, Day, Year): JULY 2, 1995
3. TIME OF DEATH: 2:30 A.M. M
4. SOCIAL SECURITY NUMBER: 212 10 3390
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 89 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Nov. 11, 1905
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): College Manor
9b. CITY, TOWN OR LOCATION OF DEATH: LUTHERVILLE
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: Towson
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 24 East Joppa Road Apt. 1204
10f. ZIP CODE: 21286
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 YRS. College (1-4 or 5 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): AT HOME
16b. KIND OF BUSINESS/INDUSTRY: OWN HOME
17. FATHER'S NAME (First, Middle, Last): Gustave Rhoby
18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret A. Mahr
19a. INFORMANT'S NAME (Type/Print): Anne M. Leimbach
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3526 Blue Coat Road Berry Hall, Maryland 21236
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Green Mount Crematory — DATE:
20c. LOCATION — City or Town, State: Baltimore Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Herbert F. Evans
22. NAME AND ADDRESS OF FACILITY: Evans Chapel of Memories 8800 Harford Road - Parkville

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebrovascular Accident — 2 weeks

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Adams
29c. LICENSE NUMBER: D32783
29d. DATE SIGNED (Month, Day, Year): JULY 3, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. JOSEPH ADAMS 8424 Osler Drive — Towson

31. DATE FILED (Month, Day, Year): JUL 06 1995
REGISTRAR'S SIGNATURE: Julia

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DHMH-18 Rev 1/89

95-3839-001

B.K.S

ITEMS: 23 PART I, 27, PER MEO FILM G-726 8/18/95 t.t

95 20419

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CLARA NICOLE IMAN

2. DATE OF DEATH (Month, Day, Year): JULY 01, 1995

3. TIME OF DEATH: 5:14 P M

4. SOCIAL SECURITY NUMBER: 232 43 8286

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): YRS.

IF UNDER 1 YEAR: MONTHS 8 DAYS

IF UNDER 24 HRS.: HOURS MIN.

7. DATE OF BIRTH (Month, Day, Year): Oct. 31, 1994

8. BIRTHPLACE (State or Foreign Country): W.Va.

9a. FACILITY NAME (If not institution, give street and number): MEMORIAL HOSPITAL E.R.

9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND

9c. COUNTY OF DEATH: ALLEGANY

RESIDENCE OF DECEDENT

10a. STATE: W.Va.

10b. COUNTY: Grant

10c. CITY, TOWN OR LOCATION: New Creek

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER: Hc 75 Box 93

10f. ZIP CODE: 26743

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 0
College (1-4 or 5+): 0

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): None

16b. KIND OF BUSINESS/INDUSTRY: None

17. FATHER'S NAME (First, Middle, Last): Samuel James Iman

18. MOTHER'S NAME (First, Middle, Maiden Surname): Tina Louise Rohrbaugh

19a. INFORMANT'S NAME (Type/Print): Samuel James Iman

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Hc 75 Box 93 New Creek, W. Va. 26743

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Maysville Cemetery DATE 7/4/95

20c. LOCATION — City or Town, State: Maysville W. Va.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Harry W. Haight

22. NAME AND ADDRESS OF FACILITY: Haight Funeral Home P.O.Box 195 Sykesville, Md. 21784

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the desth. Do not entsr the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on sach lins.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. INTERSTITIAL PNEUMONIA AND HYDROCEPHALUS EX VACUO

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. _____ DUE TO (OR AS A CONSEQUENCE OF):

c. _____ DUE TO (OR AS A CONSEQUENCE OF):

d. _____

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Wayne McCall

29c. LICENSE NUMBER: O.C.M.E

29d. DATE SIGNED (Month, Day, Year): ▶ JULY 2, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARYBETH D. KORCZYK 111 PENN STREET, BALTIMORE, MARYLAND 21201

31. DATE FILED (Month, Day, Year): JUL 06 1995

32. REGISTRAR'S SIGNATURE: Linda Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

4

95-3861-510
CIP

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-725 7/24/95 t.t

95 20420

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JAMES JENKINS			2. DATE OF DEATH (Month, Day, Year): JULY 4, 1995	3. TIME OF DEATH: 7:57 A M
4. SOCIAL SECURITY NUMBER: 220-64-5249	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 38 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 3-18-57	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 1307 EAST NORTH AVENUE		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE	9c. COUNTY OF DEATH: None	
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: None	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? X YES 2 ☐ NO	
10e. STREET AND NUMBER: 418 N. Bradford St.		10f. ZIP CODE: 21205	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES	13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Construction	16b. KIND OF BUSINESS/INDUSTRY: Unknown	
17. FATHER'S NAME (First, Middle, Last): Willie Davis		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mildred Jenkins		
19a. INFORMANT'S NAME (Type/Print): Barbara McCullers		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5402 Elsrode Ave. Balto., Md. 21214		
20a. METHOD OF DISPOSITION: X 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Zion	DATE: 7-8	20c. LOCATION — City or Town, State: Landsdowne, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Derrick C. Jones		22. NAME AND ADDRESS OF FACILITY: Derrick C. Jones Funeral Home 4611 Park Heights Ave.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. NARCOTIC AND ALCOHOL INTOXICATION
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 X YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 X Could not be determined

28a. DATE OF INJURY (Month, Day, Year): FOUND 7-4-95
28b. TIME OF INJURY: UNKNOWN
28c. INJURY AT WORK? 1 ☐ YES 2 X NO
28d. DESCRIBE HOW INJURY OCCURED: UNKNOWN
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): HOUSE
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 1307 E. NORTH AVE. BALTIMORE, MD.

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Aaron Locke MD
29c. LICENSE NUMBER: O.C.M.E.
29d. DATE SIGNED (Month, Day, Year): ▶ JULY 4, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. AARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

31. DATE FILED (Month, Day, Year): JUL 06 1995
32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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95 20421

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LORETTA M JOHNSON			2. DATE OF DEATH (Month, Day, Year): JULY 04 1995	3. TIME OF DEATH: 2:10A M
4. SOCIAL SECURITY NUMBER: 212-36-0230	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 85 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): APRIL 26, 1910	8. BIRTHPLACE (State or Foreign Country): KENTUCKY
9a. FACILITY NAME (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON	9c. COUNTY OF DEATH: BALTIMORE	
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO	
10e. STREET AND NUMBER: 1110 HIGH COUNTRY ROAD		10f. ZIP CODE: 21286	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER	16b. KIND OF BUSINESS/INDUSTRY: HOMEMAKING		
17. FATHER'S NAME (First, Middle, Last): ALBERT STEWART		18. MOTHER'S NAME (First, Middle, Maiden Surname): HANNAH KNOX		
19a. INFORMANT'S NAME (Type/Print): BEVERLY TOMLINSON		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1110 HIGH COUNTRY ROAD - BALTIMORE, MD 21286		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place): DULANEY VALLEY MEMORIAL GA	DATE: 7/7	20c. LOCATION — City or Town, State: COCKEYSVILLE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such es cerdiec or respiratory arrest, shock, or heert feilure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. BRONCHOPNEUMONIA	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. METASTATIC CARCINOMA	
DUE TO (OR AS A CONSEQUENCE OF):		
	c.	
OUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

ATRIAL FIBRILLATION
DUODENAL ULCER

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

24a. WAS AN AUTOPSY PERFORMED? 1 ☑ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☑ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Steven H. Pearlman M.D.	29c. LICENSE NUMBER: D30206	29d. DATE SIGNED (Month, Day, Year): 7/6/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): STEVEN H. PEARLMAN, M.D. GBMC		
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: Julia Thurlow Kendall	

DHMH-16 Rev 1/89

95 20422

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EVELYN JONES			2. DATE OF DEATH (Month, Day, Year): JULY 01 1995	3. TIME OF DEATH: 915 A M
4. SOCIAL SECURITY NUMBER: 072-12-0661	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 84 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): AUG. 4, 1910	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): LEVINDALE NURSING HOME			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH: N/A

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: N/A	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2435 W. BELVEDERE AVE.		10f. ZIP CODE: 21215	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ADVERTISING EXECUTIVE	16b. KIND OF BUSINESS/INDUSTRY: TELEVISION
17. FATHER'S NAME (First, Middle, Last): LEO S. KOCH		18. MOTHER'S NAME (First, Middle, Maiden Surname): RAE PERLMAN	
19a. INFORMANT'S NAME (Type/Print): MR. MANUEL DUPKIN II		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3801 CANTERBURY RD., APT. #1104, BALTO., MD. 21218	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place): HILLTOP SERVICE CORP.	DATE: 7/3/95	20c. LOCATION — City or Town, State: TOWSON, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Guy Alan Lee	22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD. 21215		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. RESPIRATORY FAILURE	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. BILATERAL PNEUMONIAS	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure; Malnutrition; Angina

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Howard B. Glenn M.D.	29c. LICENSE NUMBER: D21680	29d. DATE SIGNED (Month, Day, Year) ▶ 7/1/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 6717 Park Heights Avenue 21215

31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: Julia Chesterfield

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH-16 Rev 1/89

RKD

95-3482-510

95 20423

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
JOSEPH	JARRETT	JUNE 13 95	9:54 PM

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
	1 [X] M 2 [ ] F	45 YRS.			August 4,49	

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
UNIVERSITY S.T.U.	BALTIMORE CITY	

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland		Baltimore	1 [ ] YES 2 [ ] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
2802 Rockrose Avenue	21215	

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	1 [ ] YES 2 [ ] NO	1 [ ] YES 2 [ ] NO Specify:	Specify: black

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) in state			

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
Ronald Wade, Dir.	State Anatomy Board 655 W. Baltimore St., Balto., MD 21201

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Blunt Force Injuries of Head	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [X] YES 2 [ ] NO	1 [X] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [XX] YES 2 [ ] NO	HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURRED
1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	6/13/95	1010 M	1 [ ] YES 2 [X] NO	Subject beaten

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
STREET	3700 Blk Louanda Ave.

29a. CERTIFIER (Check only one)

1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Fraton Locke MD	O.C.M.E.	▶ JUNE 13,1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Fraton Locke, MD 111 Penn Street, Baltimore, Maryland 21201

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 30 1995	

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 Rev 1/89

95 20424

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN ERWIN KRAMER

2. DATE OF DEATH: MONTH 07 DAY 04 YEAR 95

3. TIME OF DEATH: 6:25AM M

4. SOCIAL SECURITY NUMBER: 218-07-7789

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 73 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 09 21 1921

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): Maryland Masonic Home

9b. CITY, TOWN OR LOCATION OF DEATH: Cockeysville

9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Baltimore

10c. CITY, TOWN OR LOCATION: Baltimore

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER: 1315 Chesco Ave.

10f. ZIP CODE: 21237

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO
IF YES, GIVE WAR OR DATES: WW II

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 6
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Electrician

16b. KIND OF BUSINESS/INDUSTRY: Union Electrical

17. FATHER'S NAME (First, Middle, Last): Erwin Kramer

18. MOTHER'S NAME (First, Middle, Maiden Surname): Edna Portman

19a. INFORMANT'S NAME (Type/Print): Nancy Haley

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1475 James Ave. Merritt Island, Fla. 32952

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cemetery DATE 7/7/95

20c. LOCATION — City or Town, State: Baltimore, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert M. Kratz

22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home, 6500 York Rd.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. myocardial infarction
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
hypertension

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: June Breiner MD

29c. LICENSE NUMBER: D40208

29d. DATE SIGNED (Month, Day, Year): ▶ 7/5/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): June Breiner 1205 York Rd Ste 32C Lutherville Md 21093

31. DATE FILED (Month, Day, Year): JUL 06 1995

32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

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DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 20425

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEOENT'S NAME (First, Middle, Last): JOSEPH ANTHONY KIRBY				2. DATE OF DEATH (Month, Day, Year): July 1, 1995	3. TIME OF DEATH: 1:15 PM
4. SOCIAL SECURITY NUMBER: 215-05-6036	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 77 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Oct 28, 1917	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Chesapeake Health Care			9b. CITY, TOWN OR LOCATION OF DEATH: Arnold		9c. COUNTY OF DEATH: Anne Arundel
RESIDENCE OF DECEDENT					
10a. STATE: Maryland	10b. COUNTY: NA	10c. CITY, TOWN OR LOCATION: Baltimore (BROOKLYN)			10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 642 East Patapsco Avenue		10f. ZIP CODE: 21225		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW 2 Navy	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5 +):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Retired Plumber		16b. KIND OF BUSINESS/INDUSTRY: Union Local #48	
17. FATHER'S NAME (First, Middle, Last): Leo Kirby				18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret Roach	
19a. INFORMANT'S NAME (Type/Print): Ms. Mary Cierkowski				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7707 Darcy Rd., Glen Burnie, Md. 21060	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Most Holy Redeemer Cem. DATE: 7/5/95		20c. LOCATION — City or Town, State: Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Kevin E. Ecker				22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. LUNG CARCINOMA	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated event resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [X]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Attending
29c. LICENSE NUMBER: D21776
29d. DATE SIGNED (Month, Day, Year): ▶ 7/3/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SURYA MUNDRA MD 1600 CRAIN HWY #106 GLENBURNIE MD 21061

31. DATE FILED (Month, Day, Year): JUL 06 1995
32. REGISTRAR'S SIGNATURE: Julia Wheeler-Randall

DHMH-16 Rev 1/89

Item16a 7-6-95 FilmG725 W.H.Per F/H

95 20426

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JAMES E. KNOX			2. DATE OF DEATH (Month, Day, Year): 6 30 95	3. TIME OF DEATH: 7:45 P M
4. SOCIAL SECURITY NUMBER: 217-24-3287	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 64 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): JAN 4, 1931	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): 2318 W. FAYETTE ST.		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH: N/A
RESIDENCE OF DECEDENT				
10a. STATE: MD.	10b. COUNTY: N/A	10c. CITY, TOWN OR LOCATION: BALTIMORE		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2318 W. FAYETTE ST.		10f. ZIP CODE: 21223		10g. CITIZEN OF WHAT COUNTRY? U.S.A
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION: Cab Driver CAB DRIVER		16b. KIND OF BUSINESS/INDUSTRY: CAB	
17. FATHER'S NAME (First, Middle, Last): UNK.		18. MOTHER'S NAME (First, Middle, Maiden Surname): ELIZABETH KNOX		
19a. INFORMANT'S NAME (Type/Print): PEARL KNOX	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2318 W. FAYETTE ST. BALT. MD. 21223			
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): KING MEM. PK.	DATE: 7/7/95	20c. LOCATION — City or Town, State: BALTIMORE MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Gary D. March	22. NAME AND ADDRESS OF FACILITY: GARY P. MARCH FUNERAL HOME P.A. 2704 FREDHILTON PASS BALT. MD. 21229			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Colon Carcinoma	2 yr
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive Pulmonary Disease

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Marvin J. Feldman MD

29c. LICENSE NUMBER: 007830

29d. DATE SIGNED (Month, Day, Year): ▶ July 3, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARVIN J. FELDMAN, MD. 301 ST. PAUL PL. #407 BALTO. MD. 21202

31. DATE FILED (Month, Day, Year): JUL 06 1995

32. REGISTRAR'S SIGNATURE: Julia Hawkins Randall

DHMH-16 Rev 1/89

3

1 2 1



95 20427

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Maynard James KELLER, SR.			2. DATE OF DEATH (Month, Day, Year): June 29 1995	3. TIME OF DEATH: 2:55 a M
4. SOCIAL SECURITY NUMBER: 237-22-6771	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 74 YRS. (If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.)	7. DATE OF BIRTH (Month, Day, Year): FEBRUARY 10, 1921	8. BIRTHPLACE (State or Foreign Country): ALEXANDER CO., N.C.
9a. FACILITY NAME (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE COUNTY		9c. COUNTY OF DEATH: Baltimore
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE CITY	10c. CITY, TOWN OR LOCATION: BALTIMORE		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 4505 HAMILTON AVENUE		10f. ZIP CODE: 21206		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4 or 5+): N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CARPENTER		16b. KIND OF BUSINESS/INDUSTRY: J. VINTON SCHAFER
17. FATHER'S NAME (First, Middle, Last): JAMES KELLER		18. MOTHER'S NAME (First, Middle, Maiden Surname): LEELA WALKER		
19a. INFORMANT'S NAME (Type/Print): MAYNARD KELLER, JR.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4505 HAMILTON AVENUE BALTIMORE, MARYLAND 21206		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): GARDENS OF FAITH CEMETERY DATE: JULY 1, 1995		20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]		22. NAME AND ADDRESS OF FACILITY: LASSAHN FUNERAL HOME, INC. 7401 BELAIR ROAD BALTIMORE, MARYLAND 21236-4625		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardiovascular collapse	12 hours
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Coronary ischemia	12 hours
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Luis M. Ortega, M.D.	R D 001621	▶June 29, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Luis Ortega M.D. 9000 Franklin Square Drive Baltimore Maryland 21237-3998

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUL 06 1995	[signature]

DHMH-18 Rev 1/89

2041

95 20428

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): IRVING JOSEPH LEVON
2. DATE OF DEATH — MONTH: JUNE DAY: 30 YEAR: 1995
3. TIME OF DEATH: 6:52 P.M. M
4. SOCIAL SECURITY NUMBER: 217-34-3448
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 56 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): FEB. 25, 1939
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): ST. JOSEPH HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: ROSEDALE
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 9204 APT. 1B OSWALO WAY
10f. ZIP CODE: 21237
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 10 YRS. — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): OPERATOR
16b. KIND OF BUSINESS/INDUSTRY: WESTERN ELECTRIC
17. FATHER'S NAME (First, Middle, Last): JOSEPH LEVON
18. MOTHER'S NAME (First, Middle, Maiden Surname): DOROTHY ANNA BRANDT
19a. INFORMANT'S NAME (Type/Print): SHARON E. LEVON
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7 BUSHWOOD ROAD BALTIMORE, MARYLAND 21234
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): GARDENS OF FAITH — DATE: 7-5-95
20c. LOCATION — City or Town, State: ROSEDALE, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Paul E. Evans
22. NAME AND ADDRESS OF FACILITY: EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD - PARKVILLE

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CONGESTIVE HEART FAILURE

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. AORTIC VALVE DYSFUNCTION & CORONARY ARTERY DISEASE — 4 MONTHS

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: RE-DO HEART SURGERY

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Stephen Lincoln MD
29c. LICENSE NUMBER: D23045
29d. DATE SIGNED (Month, Day, Year): JULY 3, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR STEPHEN Lincoln 120 SISTER PIERRE DRIVE Towson, MD. 21204

31. DATE FILED (Month, Day, Year): JUL 06 1995
32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DHMH-18 Rev 1/89

15

95 20429

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ALICE LARKIN			2. DATE OF DEATH (Month, Day, Year): JULY 5 95	3. TIME OF DEATH: 145p. M
4. SOCIAL SECURITY NUMBER: 055-30-9563	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 85 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): March 20, 10	8. BIRTHPLACE (State or Foreign Country): Ireland
9a. FACILITY NAME (If not institution, give street and number): 6336 Cedar Lane		9b. CITY, TOWN OR LOCATION OF DEATH: Columbia		9c. COUNTY OF DEATH: Howard County

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Howard County	10c. CITY, TOWN OR LOCATION: Columbia	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 6336 Cedar Lane		10f. ZIP CODE: 21044	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): beautician	16b. KIND OF BUSINESS/INDUSTRY: beauty shop	
17. FATHER'S NAME (First, Middle, Last): Edward Clarke		18. MOTHER'S NAME (First, Middle, Maiden Surname): Alice Finley	
19a. INFORMANT'S NAME (Type/Print): Mr. Thomas Larkin		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6336 Cedar Lane, Columbia, Maryland 21044	

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Calvary Cemetery	DATE: 7-8-95	20c. LOCATION — City or Town, State: Sunnyside, NY
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] M00535		22. NAME AND ADDRESS OF FACILITY: Slack Funeral Home, P.A. Ellicott City, Maryland 21043	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, auch es cardiec or respiratory arrest, shock, or heart failure. Liet only one ceuse on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Finel disease or condition resulting in death) → a. Carcinoma of the Pancreas — 4 months

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury that initiated evente resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. OUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERREO TO MEOICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF OEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF OEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. OATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. OESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, and dua to the cause(a) end manner as stated.
2 ☐ MEDICAL EXAMINER: On the beeis of examination and/or investigation, in my opinion, deeth occured at the time, data and piece, and dua to the cause(e) end manner as steted.

29b. SIGNATURE ANO TITLE OE CERTIFIER: William Flowers MD	29c. LICENSE NUMBER: D20708	29d. OATE SIGNED (Month, Day, Year): ▶ July 5, 1995
30. NAME ANO AOORESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print): William Flowers MD 11055 Little Patuxent Columbia Md		
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: [signature]	

DHMH-16 Rev 1/89

Items1,20c&22,g-725,7-6-95,perf.h.,dk

95 20430

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ~~BETTY J. LAPE~~ Betty Jane Lape				2. DATE OF DEATH: MONTH JULY DAY 01 YEAR 1995	3. TIME OF DEATH: 4. 21 P M
4. SOCIAL SECURITY NUMBER: 235-38-3452	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 68 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Jan 27, 1927	8. BIRTHPLACE (State or Foreign Country): W. Virginia
9a. FACILITY NAME (If not institution, give street and number): Harbor Hospital Center			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH: NA

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: NA	10c. CITY, TOWN OR LOCATION: Baltimore (Brooklyn)	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3701 Saint Margaret St.		10f. ZIP CODE: 21225	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5 +)	16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Housewife and Mother	
17. FATHER'S NAME (First, Middle, Last): James David Rawls		18. MOTHER'S NAME (First, Middle, Maiden Surname): Oma M. Clevenger	
19a. INFORMANT'S NAME (Type/Print): Mr. Telford J. Lape		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3701 St. Margaret St., Baltimore, Md. 21225	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery DATE 7/5/95	20c. LOCATION — Baltimore ~~Baltimore~~, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Kevin E. Ecker		22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home of Brooklyn 237 E. ~~Patapsco~~ Ave., Balto., Md. 21225 Potapsco	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Hypoxic Brain damage	48h.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Ventricular arrythmia	48h.
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Myocardial infarction	48h
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. Hypertension	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. moderate chronic COPD NIDDM

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☒ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF OEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: HOUSE STAFF	29c. LICENSE NUMBER: AS244161413	29d. DATE SIGNED (Month, Day, Year): July 1, 95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MUHAMMAD NAJAM GHOR HARBOR HOSPITAL CENTER BALTIMORE MD21225		
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: Jack Wheeler Randall	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Pages 1, 2, 3 should accompany the body to the cemetery or crematory as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10

95 20431

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN B. LISTON			2. DATE OF DEATH (Month, Day, Year): June 27 1995	3. TIME OF DEATH: 11:50 PM
4. SOCIAL SECURITY NUMBER: 215-42-2363	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 52 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 1,1943	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Perrypoint V.A. Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Perry Point		9c. COUNTY OF DEATH: Cecil

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Lutherville	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 7909 Knollwood Rd.		10f. ZIP CODE: 21286	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: Vietnam	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12):	College (1-4 or 5+): 4 yrs	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Accountant	16b. KIND OF BUSINESS/INDUSTRY: Accounting
17. FATHER'S NAME (First, Middle, Last): William E. Liston		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Olliger	
19a. INFORMANT'S NAME (Type/Print): Conrad A. Bruns		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2873 Hidden Oak Dr. Johns Island, S.C.29455	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Hilltop Service Corp. DATE: 7/5/95	20c. LOCATION — City or Town, State: Towson, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]		22. NAME AND ADDRESS OF FACILITY: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. SEPSIS	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. PNEUMONIA	
DUE TO (OR AS A CONSEQUENCE OF):		
	c. LANNEC CIRRHOSIS	
DUE TO (OR AS A CONSEQUENCE OF):		
	d. Ethanol Dependent	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

Pasterella Multicida Bacteremina

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [X]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA. OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D41608	29d. DATE SIGNED (Month, Day, Year): ▶ 6/28/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): EUGENE CRAIG, M.D. VAMC PERRY POINT, MD 21902		
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: [signature]	

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2441

Item: 4 per F.H. G-726 8/8/95 reb
Item17,g-725,7-12-95,perf.h.,dk

95 20432

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
MEREDITH	L.	LINDUNG	July 3, 1995	1:50 A.M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
016-30-~~7285~~ 7582	1 ☐ M 2 ☒ F	57 YRS.			June 22, 1938	Ca.

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Stella Maris Hospice	Towson	Baltimore

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Md.	Baltimore	Hydes	1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
13128 Long Green Pike	21082	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☒ YES 2 ☐ NO — Vietnam	1 ☐ YES 2 ☒ NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)	Home Maker	Own Home
	4		

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Thomas J. ~~Mikulus~~ Mikulis	Mildred Frances Carley

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mr. John Lindung	13128 Long Green Pike Hydes, Md. 21082

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	St. John's Cemetery	7/7/95	Hydes, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
	Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. OVARIAN CARCINOMA	6 mos.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Kendall R Faulkner MD	D25643	▶ 7/3/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUL 06 1995	Julia Mueller Roberts

DHMH-16 Rev 1/89

95 20433

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): SARAH LUCHINSKY			2. DATE OF DEATH (Month, Day, Year): JULY 01 1995	3. TIME OF DEATH: 1836 M
4. SOCIAL SECURITY NUMBER: 216-07-3719	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 84 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): JULY 10,1910	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): NORTHWEST HOSPITAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: RANDALLSTOWN	9c. COUNTY OF DEATH: BALTIMORE	

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: N/A	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3937-B CLARKS LANE		10f. ZIP CODE: 21215	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): BOOKKEEPER	16b. KIND OF BUSINESS/INDUSTRY: HECHT COMPANY	
17. FATHER'S NAME (First, Middle, Last): JOSEPH BIORSKI		18. MOTHER'S NAME (First, Middle, Maiden Surname): FANNY KAMINSKY	
19a. INFORMANT'S NAME (Type/Print): MRS. JOAN GREBOW		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6804 SYLVALE COURT, BALTO., MD. 21209	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): B'NAI ISRAEL CONG. DATE: 7/3/95	20c. LOCATION — City or Town, State: BALTIMORE, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jay Alan Levinson		22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD. 21215	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	MYOCARDIAL INFARCTION.	20 HOURS
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b.	ARTERIOSCLEROSIS	20 YEARS
DUE TO (OR AS A CONSEQUENCE OF): c.		
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.: DIABETES MELLITUS-INSULIN DEPENDANT

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD	29c. LICENSE NUMBER: D151470	29d. DATE SIGNED (Month, Day, Year): 7/1/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): IRA SUNSHINE MD 6210 PARK HEIGHTS AVE. BALTIMORE, MD. 21215		
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR SIGNATURE: Julia	

DHMH-18 Rev 1/89

4

95 20434

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LYUBOV S. LUBMAN			2. DATE OF DEATH (Month, Day, Year): JULY 1 1995	3. TIME OF DEATH: 12:15P M
4. SOCIAL SECURITY NUMBER: 217-33-5191	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 48 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): NOV. 11, 1946	8. BIRTHPLACE (State or Foreign Country): KIEV, RUSSIA
9a. FACILITY NAME (If not institution, give street and number): 33 JONES VALLEY CIRCLE		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE	9c. COUNTY OF DEATH: BALTIMORE	
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO	
10e. STREET AND NUMBER: 33 JONES VALLEY CIRCLE		10f. ZIP CODE: 21209	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MUSICIAN	16b. KIND OF BUSINESS/INDUSTRY: MUSIC		
17. FATHER'S NAME (First, Middle, Last): SHLOMO BERNSTEIN		18. MOTHER'S NAME (First, Middle, Maiden Surname): LYUCIA KANEZKAYA		
19a. INFORMANT'S NAME (Type/Print): MR. YURIY LUBMAN		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 33 JONES VALLEY CIRCLE, BALTO., MD. 21209		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): HAR SINAI CONGREGATION DATE: 7/2/95	20c. LOCATION — City or Town, State: OWINGS MILLS, MD.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jay Alan Levinson		22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD. 21215		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Malignant Melanoma DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☑ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: H Friedman MD	29c. LICENSE NUMBER: D01703	29d. DATE SIGNED (Month, Day, Year) ▶ 7/1/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): H Ronald Friedman 23 Crossroads Dr. Owings Mills, MD 21117		
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: Julia Gardner-Randall	

DHMH-1S Rev 1/89

Items1,6 7-6-95 FilmG725 W.H.Per F/H

95 20435

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ~~LUCILLE~~ Lucile Bull Lewis ~~LEWIS~~
2. DATE OF DEATH: MONTH 7 DAY 3 YEAR 95
3. TIME OF DEATH: 12:30 PM
4. SOCIAL SECURITY NUMBER: 216-07-0092
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): ~~93~~ ~~92~~ YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): DECEMBER 21, 1901
8. BIRTHPLACE (State or Foreign Country): BALTIMORE, MARYLAND
9a. FACILITY NAME (If not institution, give street and number): MERIDIAN NURSING CENTER-PERRING PARKWAY
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE COUNTY
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: BALTIMORE CITY
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2701 WESTFIELD AVENUE
10f. ZIP CODE: 21214
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): N/A
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PROOF READER
16b. KIND OF BUSINESS/INDUSTRY: WAVERLY PRESS
17. FATHER'S NAME (First, Middle, Last): JOHN A. BULL
18. MOTHER'S NAME (First, Middle, Maiden Surname): IDA LILLIE KOLLER
19a. INFORMANT'S NAME (Type/Print): PATRICIA D. VANE
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1400 KINGSWAY ROAD BALTIMORE, MARYLAND 21218
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): GARDENS OF FAITH CEMETERY — DATE: JULY 8, 1995
20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Heather Lassahn
22. NAME AND ADDRESS OF FACILITY: LASSAHN FUNERAL HOME, INC. 7401 BELAIR ROAD BALTIMORE, MARYLAND 21236-4625

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such ea cerdiac or reapiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. 1. Pneumonia + atelectasis terminal
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. 2 COPD - Chronic Bronchitis + emphysema
DUE TO (OR AS A CONSEQUENCE OF):
c. 3 Dementia due to Multi-infarct
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Donald W. Mintzer M.D.
29c. LICENSE NUMBER: D 07296
29d. DATE SIGNED (Month, Day, Year): ▶ 7/3/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DONALD W. MINTZER, M.D. 3009 EVERGREEN AVENUE BALTIMORE, MARYLAND 21214
31. DATE FILED (Month, Day, Year): JUL 06 1995
32. REGISTRAR'S SIGNATURE: M. Hamilton Randall

DHMH-16 Rev 1/89

95 20436

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HILLARD LIVINGSTON			2. DATE OF DEATH — MONTH: JULY; DAY: 3rd; YEAR: 1995	3. TIME OF DEATH: 10:40 AM
4. SOCIAL SECURITY NUMBER: 213-03-3466	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 77 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): DEC. 20, 1917	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): NORTHWEST HOSPITAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: RANDALLSTOWN		9c. COUNTY OF DEATH: BALTIMORE
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: BALTIMORE		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 6950 BROOKMILL ROAD, APT. 2-C		10f. ZIP CODE: 21215		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SALESMAN	16b. KIND OF BUSINESS/INDUSTRY: JEWELRY		
17. FATHER'S NAME (First, Middle, Last): MEYER LIVINGSTON		18. MOTHER'S NAME (First, Middle, Maiden Surname): MINNIE HALPERN		
19a. INFORMANT'S NAME (Type/Print): MRS. SONIA LIVINGSTON		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6950 BROOKMILL RD, APT. 2-C BALTIMORE, MD 21215		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): MIKRO KODESH BETH ISRAEL	DATE: 7-5-1995	20c. LOCATION — City or Town, State: BALTIMORE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Sol Levinson	22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. MALIGNANT MELANOMA with METASTASIS	2 YEARS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: PROSTATIC CANCER

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
K.S. RAO, M.D.	D43462	July 3rd 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): K.S. RAO, M.D., NORTHWEST HOSPITAL CENTER RANDALLSTOWN, MD

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUL 06 1995	Julia Strother Randall

DHMH-18 Rev 1/89

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95 20437

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CHARLOTTE MARIE McDONALD
2. DATE OF DEATH (Month, Day, Year): JULY 2 1995
3. TIME OF DEATH: 10 PM
4. SOCIAL SECURITY NUMBER: 245-24-8079
5. SEX: 1 ☐ M 2 ☑ F
6. AGE (In yrs. last birthday): 70 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): AUG 6, 1924
8. BIRTHPLACE (State or Foreign Country): NORTH CAROLINA
9a. FACILITY NAME (If not institution, give street and number): 31 ATHERTON Rd
9b. CITY, TOWN OR LOCATION OF DEATH: LUTHERVILLE
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: LUTHERVILLE
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 31 ATHERTON Rd.
10f. ZIP CODE: 21093
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): 1
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary
16b. KIND OF BUSINESS/INDUSTRY: BALTIMORE Co. SCHOOLS
17. FATHER'S NAME (First, Middle, Last): CHARLES MARVIN McGhee
18. MOTHER'S NAME (First, Middle, Maiden Surname): ADA CATHERINE LACKEY
19a. INFORMANT'S NAME (Type/Print): DARRIA M. KIRK
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6008 Glen View Dr. Virginia Beach VA 23464
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Green Mount Cemetery — DATE: 7/10/95
20c. LOCATION — City or Town, State: Baltimore Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert W. Reese
22. NAME AND ADDRESS OF FACILITY: EVANS CHAPEL of CHIMES, 2325 YORK Rd. TIMONIUM, Md. 21093

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Hypertension	>5yrs
DUE TO (OR AS A CONSEQUENCE OF): b.	Hyperlipidemia	>5yrs
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.		
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Patricia Tom MD
29c. LICENSE NUMBER: D37898
29d. DATE SIGNED (Month, Day, Year): July, 6, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. PATRICIA TOM, 2205 YORK Rd. TIMONIUM, Md. 21093
31. DATE FILED (Month, Day, Year): JUL 06 1995
32. REGISTRAR'S SIGNATURE

OHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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95 20438

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): John MAGILL		2. DATE OF DEATH (Month, Day, Year): July 02, 1995	3. TIME OF DEATH: 4:50 A.M.
4. SOCIAL SECURITY NUMBER: 212-20-6854	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 69 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 8-6-25
8. BIRTHPLACE (State or Foreign Country): MD			
9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Rossville	9c. COUNTY OF DEATH: Baltimore County	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: N/A	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 27 S. Potomac St.	10f. ZIP CODE: 21224	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Actor	16b. KIND OF BUSINESS/INDUSTRY: Entertainment	
17. FATHER'S NAME (First, Middle, Last): John J. Magill	18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Ackerman		
19a. INFORMANT'S NAME (Type/Print): Kathy Sotaski	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8206 Edwill Ave. Baltimore, Md 21237		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Moreland Memorial Park DATE: 7-5-95	20c. LOCATION — City or Town, State: Parkville, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Denis S Kelly	22. NAME AND ADDRESS OF FACILITY: Cvach/Rosedale Funeral Home 1211 Chesaco Ave.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pulseless Electrical Activity	30 min
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Massive Anterior Lateral Myocardial Infarction	45 min
DUE TO (OR AS A CONSEQUENCE OF):		
	c.	
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD

29c. LICENSE NUMBER: R.D. 1769

29d. DATE SIGNED (Month, Day, Year): ▶ 7/2/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Samuel Eng, MD 9000 Franklin Square Drive Baltimore Md. 21237

31. DATE FILED (Month, Day, Year): JUL 06 1995

32. REGISTRAR'S SIGNATURE: Julia Thurber-Randall

DHMH-16 Rev 1/89

Item1,g-725,7-6-95,perf.h.,dk

95 20439

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Pages 1, 2, 3 should be used as the burial-transit permit.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ~~Dora Batts~~ Dora Mae Batts- Mack
2. DATE OF DEATH (Month, Day, Year): July 4 1995
3. TIME OF DEATH: 2:29 A M
4. SOCIAL SECURITY NUMBER: 213-26-0674
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 74 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): June 4 1921
8. BIRTHPLACE (State or Foreign Country): NORTH CAROLINA
9a. FACILITY NAME (If not institution, give street and number): SINAI HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH: N/A

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: N/A
10c. CITY, TOWN OR LOCATION: BALTIMORE CITY
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2522 LOYOLA SOUTHWAY
10f. ZIP CODE: 21215
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th grade; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Silk Presser
16b. KIND OF BUSINESS/INDUSTRY: Athens Cleaners
17. FATHER'S NAME (First, Middle, Last): Bob Bates
18. MOTHER'S NAME (First, Middle, Maiden Surname): Lula Bates
19a. INFORMANT'S NAME (Type/Print): Dorothy Johnson
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2522 Loyola Southway, Baltimore, MD. 21215
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): BALTIMORE CEMETERY DATE: 7/8
20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Barbara A. Brown
22. NAME AND ADDRESS OF FACILITY: WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Uremia / Renal Failure

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Insulin Dependent Diabetes Mellitus

DUE TO (OR AS A CONSEQUENCE OF):

c. 1

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

Urinary tract infection, hypertension, cerebrovascular accidents - seven total

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: K. Y. Chung MD
29c. LICENSE NUMBER: AS2402321 KYC 9914
29d. DATE SIGNED (Month, Day, Year) ▶ July 4, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Sinai Hospital 2401 W. Belvedere Ave Baltimore MD 21215

31. DATE FILED (Month, Day, Year): JUL 06 1995
32. REGISTRAR'S SIGNATURE: Jane Marie Randall

DHMH-16 Rev 1/89

6

95 20440

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CATHERINE R. MOSCATI
2. DATE OF DEATH (Month, Day, Year): JULY 5 1995
3. TIME OF DEATH: 11:31 A M
4. SOCIAL SECURITY NUMBER: 212-32-3441
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 96 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): Nov. 21, 1898
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): St. Joseph's Nursing Home
9b. CITY, TOWN OR LOCATION OF DEATH: Catonsville
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Reisterstown
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 200 Walgrove Rd.
10f. ZIP CODE: 21136
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): House Keeper
16b. KIND OF BUSINESS/INDUSTRY: Catholic Rectory
17. FATHER'S NAME (First, Middle, Last): Joseph D'Antoni
16. MOTHER'S NAME (First, Middle, Maiden Surname): Carmella D'Antoni
19a. INFORMANT'S NAME (Type/Print): Joseph J. Moscati
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 200 Walgrove Rd.,Reisterstown, Md. 21136
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place): Holy Redeemer Cem. DATE: July 8, 1995
20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: H. J. Eckhardt
22. NAME AND ADDRESS OF FACILITY: Eckhardt Funeral Chapel 21117 — 11605 Reisterstown Rd., Owings Mills, Md.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Dehydration DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b.	Chronic Sepsis DUE TO (OR AS A CONSEQUENCE OF):	
c.	DUE TO (OR AS A CONSEQUENCE OF):	
d.		

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.: Arthritis

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Alejandro Mejia MD
29c. LICENSE NUMBER: D08780
29d. DATE SIGNED (Month, Day, Year): 7/5/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ALEJANDRO MEJIA MD.
31. DATE FILED (Month, Day, Year): JUL 06 1995
32. REGISTRAR'S SIGNATURE: Julia Rhodes Randall

DHMH-16 Rev 1/89

95 20441

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Sister Mary Joseph Morrissey
2. DATE OF DEATH (Month, Day, Year): June 25, 1995
3. TIME OF DEATH: 2:50 A M
4. SOCIAL SECURITY NUMBER: 218-68-8345
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 77 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): June 18, 1918
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Villa Assumpta, 6401 N. Charles St.
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 6401 N. Charles St.
10f. ZIP CODE: 21212
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 + training Cert. | College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher
16b. KIND OF BUSINESS/INDUSTRY: Education
17. FATHER'S NAME (First, Middle, Last): Michael Joseph Morrissey
18. MOTHER'S NAME (First, Middle, Maiden Surname): Jennie Ida McNew
19a. INFORMANT'S NAME (Type/Print): S. Bernice Feilinger, SSND
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6401 N. Charles St., Baltimore, Md. 21212
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Villa Maria — DATE: 6/28
20c. LOCATION — City or Town, State: Glen Arm, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dennis Stephen Kenakes
22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home, 6500 York Road Baltimore, MAryland 21212

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Aspiration pneumonia	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Senile Dementia	
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.: Catatonic Schizophrenia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: J Boas MD
29c. LICENSE NUMBER: D15871
29d. DATE SIGNED (Month, Day, Year): ▶ 7/5/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Lawrence Boas, M. D. 54 Scott Adam Rd., Cockeysville, Md. 21030
31. DATE FILED (Month, Day, Year): JUL 0 6 1995
32. REGISTRAR'S SIGNATURE: Julia Strudwick Randall

DHMH-16 Rev 1/89

95 20442

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): SUSAN MACDONALD MOSKOWITZ			2. DATE OF DEATH (Month, Day, Year): July 5th 1995	3. TIME OF DEATH: 5:05 AM
4. SOCIAL SECURITY NUMBER: 046-34-3329	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 51 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): July 1, 1944	8. BIRTHPLACE (State or Foreign Country): Connecticut
9a. FACILITY NAME (If not institution, give street and number): 1634 East Baltimore Street		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH: N/A

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: N/A	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1634 East Baltimore Street		10f. ZIP CODE: 21231	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 5+ years	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Attorney	16b. KIND OF BUSINESS/INDUSTRY: Legal
17. FATHER'S NAME (First, Middle, Last): Berton MacDonald		18. MOTHER'S NAME (First, Middle, Maiden Surname): Emily Miller	
19a. INFORMANT'S NAME (Type/Print): Robert E. Moskowitz		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1634 East Baltimore Street Baltimore, MD 21231	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Greenmount Crematory DATE: July 6, 95	20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Thomas Joseph Boyle		22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home Inc. 6500 York Road, Baltimore, MD 21212	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. RESPIRATORY ARREST	MINUTES
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. BREAST CANCER	10 YRS
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☒ Other (Specify) HOSPICE

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D06933	29d. DATE SIGNED (Month, Day, Year): ▶ JULY 5 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 101 W READ ST SUITE 719

31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: [signature]

12

DHMH-18 Rev 1/89

95 20443

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Myrtle Irene Hanky-Marshall			2. DATE OF DEATH (Month - Day - Year): 7 - 4 - 95	3. TIME OF DEATH: 1828 M
4. SOCIAL SECURITY NUMBER: 218-01-0256	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 92 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Nov. 21, 1902	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Carroll County General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Westminster		9c. COUNTY OF DEATH: Carroll
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Baltimore		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3403 Kimble Road		10f. ZIP CODE: 21207		10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Sales	16b. KIND OF BUSINESS/INDUSTRY: Stewart's & Company		
17. FATHER'S NAME (First, Middle, Last): Edward Lanham		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ella Kagle		
19a. INFORMANT'S NAME (Type/Print): Mrs. Norma Kuhn Marshall	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3509 Abbie Place Baltimore, MD 21244			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Druid Ridge Cemetery	DATE: 7/7	20c. LOCATION — City or Town, State: Pikesville, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James B Covey	22. NAME AND ADDRESS OF FACILITY: Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Ventricular Asystole	minutes
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Acute myocardial infarction	2 days
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Emphysema

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Chitra Nagarajan MD	29c. LICENSE NUMBER: D18000	29d. DATE SIGNED (Month, Day, Year): 7-5-95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CHITRA CHELLI NAGARAJAN. 700 Apollard West Quincy MD 21771		
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: John Blanchard	

DHMH-18 Rev 1/89

95 20444

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)				
George	Herman	Miller (Miller)		
2. DATE OF DEATH (Month) 7	(Day) 2	(Year) 95	3. TIME OF DEATH 2:30 PM	
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
226-22-3318A	1 [X] M 2 [ ] F	68 YRS.		
7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)			
Oct. 21, 1926	Maryland			
9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH		
Carroll County General Hospital	Westminster	Carroll		

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Carroll	Westminster	1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?	
872 Elmwood Ct.	21158	United States	

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: Korean	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12): 12th	College (1-4 or 5+):	Ret: Installer	A T & T
17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NAME (First, Middle, Maiden Surname)	
Herman J. Miller		Emma Baylas	
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Mrs. Mary Miller		872 Elmwood Ct. Westminster, MD 21158	

20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
	Carroll Cremation Service	7/5	Hampstead, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FACILITY	
▶ James B. Corey		Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Atherosclerotic Cardiovascular Disease	4yrs
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Richard Jones MD	D05905	▶ 3 Jul 95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		
DR. RICHARD JONES MD. CCGH 200 MEMORIAL AVE. WESTMINSTER MD		
31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE	
JUL 06 1995	John Luther Riddell	

DHMH-16 Rev 1/89

95 20445

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Bertha Miles			2. DATE OF DEATH (Month, Day, Year): July 4, 1995	3. TIME OF DEATH: 10:50 A M
4. SOCIAL SECURITY NUMBER: 214-76-6195	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 97 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): June 11, 1898	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Loch Raven Meridian Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: Towson		9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Md	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Parkville	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 2807 Oakcrest Ave.		10f. ZIP CODE: 21234	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4 or 5+): N/A	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Home	
17. FATHER'S NAME (First, Middle, Last): Harry Fiddis		18. MOTHER'S NAME (First, Middle, Maiden Surname): Unknown	
19a. INFORMANT'S NAME (Type/Print): Mrs. Eugenia T. McCluskey		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2807 Oakcrest Ave. Balto., Md. 21234	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Holy Redeemer Cem/	DATE: 7/7	20c. LOCATION — City or Town, State: Balto., Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jody D. Smith		22. NAME AND ADDRESS OF FACILITY: Hartley Miller Funeral Home 7527 Harford Rd. Balto., Md. 21234	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Stroke	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Fever	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Blindness Malnutrition

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO	

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ ND / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D15414	29d. DATE SIGNED (Month, Day, Year): 7/5/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): VUONG VU NGUYEN, MD 1900 E Joppa Rd Balto MD 21234		
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: [signature]	

3

DHMH-16 Rev 1/89

95 20446

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Barret Milton			2. DATE OF DEATH (Month, Day, Year): 06-18-95	3. TIME OF DEATH: 2345 PM
4. SOCIAL SECURITY NUMBER: 527-28-6905	5. SEX: 1 ☐ M 2 ☐ F	6. AGE (In yrs. last birthday): 73 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 7-31-1921	8. BIRTHPLACE (State or Foreign Country): D.C.
9a. FACILITY NAME (If not institution, give street and number): Mariner Health Care Center		9b. CITY, TOWN OR LOCATION OF DEATH: Laurel		9c. COUNTY OF DEATH: Prince Georges

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince Georges	10c. CITY, TOWN OR LOCATION: Laurel	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 14200 Laurel Park Drive		10f. ZIP CODE: 20707	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NAME (First, Middle, Maiden Surname)	
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald Wade, Dir.		22. NAME AND ADDRESS OF FACILITY: State Anatomy Board 655 W. Baltimore ST., Balto., MD 21201	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CONGESTIVE HEART FAILURE

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PNEUMONIA
ORGANIC BRAIN SYNDROME

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD	29c. LICENSE NUMBER: D24997	29d. DATE SIGNED (Month, Day, Year): 6/18/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): LUIS A. CASAS M.D. 8317 CHERRY LANE LAUREL MD 20707

31. DATE FILED (Month, Day, Year): JUN 30 1995	32. REGISTRAR'S SIGNATURE: [illegible] Randall

OHMH-16 Rev 1/89

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95 20447

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HARRY MACER			2. DATE OF DEATH (Month, Day, Year): JUNE 24 1995	3. TIME OF DEATH: 11:55 PM
4. SOCIAL SECURITY NUMBER: 217-03-3890	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 89 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): December 21,05	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): SINAI HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY	9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: 3416 Retlaw Road		10f. ZIP CODE: 21207	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: 1943-1945	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12	College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher	16b. KIND OF BUSINESS/INDUSTRY: Education
17. FATHER'S NAME (First, Middle, Last): James Richard Macer		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Elizabeth Manokoo	
19a. INFORMANT'S NAME (Type/Print): Golden Macer		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1300 E. Lafayette St. Balto., MD 21217	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald Wade, Dir.		22. NAME AND ADDRESS OF FACILITY: State Anatomy Board 655 W. Baltimore St., Balto., MD 21201	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Atherosclerotic cardiovascular disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Amyotrophic lateral sclerosis

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [X]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: O.C.M.E	29d. DATE SIGNED (Month, Day, Year): JUNE 25,1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201		
31. DATE FILED (Month, Day, Year): JUN 30 1995	32. REGISTRAR'S SIGNATURE: Jan Davidson Randall	

DHMH-16 Rev 1/89

95 20448

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Alfred Mitchell
2. DATE OF DEATH — MONTH: June DAY: 20, YEAR: 1995
3. TIME OF DEATH: 305A M
4. SOCIAL SECURITY NUMBER: 220-36-5585
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 54 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): September 20,40
8. BIRTHPLACE (State or Foreign Country):
9a. FACILITY NAME (If not institution, give street and number): Joseph Richie Hospice
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: 265 Exter
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: 265 Exeter Street
10f. ZIP CODE: 21202
10g. CITIZEN OF WHAT COUNTRY?
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last):
18. MOTNER'S NAME (First, Middle, Maiden Surname):
19a. INFORMANT'S NAME (Type/Print):
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code):
20a. METNOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) in state
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place) — DATE:
20c. LOCATION — City or Town, State:
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald Wade, Dir.
22. NAME AND ADDRESS OF FACILITY: State Anatomy Board, 655 W. Baltimore St., Balto., MD 21201

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b.	Respiratory Arrest	5minutes
DUE TO (OR AS A CONSEQUENCE OF): c.	Malnutrition	2mos
DUE TO (OR AS A CONSEQUENCE OF): d.	Carcinoma Esophagus	3mos.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [✓]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [✓] Other (Specify) Hospice
27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER:
29c. LICENSE NUMBER: D085500
29d. DATE SIGNED (Month, Day, Year): ▶ 6-21-95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Robert C. Irwin MD 838 N. Gilmor St Balto Md 21201
31. DATE FILED (Month, Day, Year): JUN 30 1995
32. REGISTRAR'S SIGNATURE: for Robert

OHMH-16 Rev 1/89

95 20449

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Hilda May Myers			2. DATE OF DEATH (Month, Day, Year): JUNE 14, 1995	3. TIME OF DEATH: 0645 M
4. SOCIAL SECURITY NUMBER: 220-07-6003	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): April 23, 19	8. BIRTHPLACE (State or Foreign Country): West Virginia
9a. FACILITY NAME (If not institution, give street and number): Washington County Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown		9c. COUNTY OF DEATH: Washington
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Sharpsburg		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 18420 Mount Lock Hill Road		10f. ZIP CODE: 21782		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5 +)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Charles William Spencer		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ruth Violet Wisner		
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald Wade, Dir.		22. NAME AND ADDRESS OF FACILITY: State Anatomy Board 655 W. Baltimore St., Balto,. MD. 21201		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mods of dying, such es cerdiec or respiratory arrest, shock, or heart failure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition resulting in death) →	a. Pneumonia	3 wks
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Pericardial Effusion	4 wks
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Acute Renal Failure	Chronic
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. Congestive Heart Failure	Chronic

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic obstructive lung disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD	29c. LICENSE NUMBER: D44996.	29d. DATE SIGNED (Month, Day, Year): June 27th, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ZAFAR MALIK 20311 LAPPANS RD BOONSBORO MD 21713

31. DATE FILED (Month, Day, Year): JUN 30 1995	32. REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89

RKD
95-3353-510
95-139

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-725 7/24/95 t.t

95 20450

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)			3. TIME OF DEATH
SAMUEL	TITUS	MYLES, JR.	JUNE	7	95	8:20 PM

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
	1 [X] M 2 [ ] F	36 YRS.			May 18, 59	

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
2239 DRUID HILL AVE	BALTIMORE CITY	

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland		Baltimore	1 [ ] YES 2 [ ] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
208 Laurens Street	21217	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] YES 2 [ ] NO	1 [ ] YES 2 [ ] NO Specify:	Specify: black

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) in state			

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
Ronald Wade, Dir.	State Anatomy Board 655 W. Baltimore St., Balto., MD 21201

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. MULTIPLE INJURIES	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [X] YES 2 [ ] NO	1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [X] YES 2 [ ] NO	HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) VACANT HOUSE

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURRED
1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	6-7-95 FOUND	8:13 PM	1 [ ] YES 2 [X] NO	SUBJECT FELL INTO BASEMENT

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
FOUND IN HOUSE	2239 DRUID HILL AVE. BALTIMORE, MD.

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
	O.C.M.E.	▶ JUNE 8,1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
MARIO F. GOLIA JR MD 111 Penn Street, Baltimore, Maryland 21201

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 30 1995	

DHMH-16 Rev 1/89

95 20451

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARY CECELIA MARLEY			2. DATE OF DEATH: MONTH 7 DAY 4 YEAR 95	3. TIME OF DEATH: 3:45pm M
4. SOCIAL SECURITY NUMBER: 216-28-4858	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 64 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): August 26, 1930	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Carroll County General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Westminster		9c. COUNTY OF DEATH: Carroll

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Carroll County	10c. CITY, TOWN OR LOCATION: Westminster	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 2329 Sams Creek Road		10f. ZIP CODE: 21157	10g. CITIZEN OF WHAT COUNTRY?: U.S.A

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5 +):	16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Data Inputer	16b. KIND OF BUSINESS/INDUSTRY: Clerical	
17. FATHER'S NAME (First, Middle, Last): Howard Leon Collins		18. MOTHER'S NAME (First, Middle, Maiden Surname): Eva Susanna Wrightson	
19a. INFORMANT'S NAME (Type/Print): Mr. Robert T. Marley		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2329 Smas Creek Road Westminster, MD 21157	
20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Lake View Mem. Park — DATE: 7/8/95	20c. LOCATION — City or Town, State: Sykesville, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Brian R. Haight		22. NAME AND ADDRESS OF FACILITY: HAIGHT FUNERAL HOME (P.O. Box 195) Sykesville, MD 21784 (410)-795-1400	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complicetione that ceused the deeth. Do not enter the mode of dying, such as cardiec or reepiretory arreet, shock, or heert feilure. List only one ceuee on eech line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Metastatic small cell lung cancer
DUE TO (OR AS A CONSEQUENCE OF):
b. Cancer Obstructive Lung Disease

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
DUE TO (OR AS A CONSEQUENCE OF):
c. Hypercalcemia
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Patrick Turnes	29c. LICENSE NUMBER: D20806	29d. DATE SIGNED (Month, Day, Year) ▶ 7/5/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PATRICK TURNES 1425 Liberty Road Eldersburg MD 21784		
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: [illegible] Randall	

12

DHMH-16 Rev 1/89

95 20452

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Carol Ann Thomas Nikolsky			2. DATE OF DEATH (Month, Day, Year): June 30 1995	3. TIME OF DEATH: 8:00 p M
4. SOCIAL SECURITY NUMBER: 205-32-8537	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 55 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 17, 1940	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): 5429 Smooth Meadow Way		9b. CITY, TOWN OR LOCATION OF DEATH: Columbia		9c. COUNTY OF DEATH: Howard
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Howard	10c. CITY, TOWN OR LOCATION: Columbia		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 5429 Smooth Meadow Way		10f. ZIP CODE: 21044		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary Personnel	16b. KIND OF BUSINESS/INDUSTRY: Rouse Company	
17. FATHER'S NAME (First, Middle, Last): Frank Thomas		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ruth Robertson Thomas		
19a. INFORMANT'S NAME (Type/Print): Ms. Ruth Thomas		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5429 Smooth Meadow Way, Columbia, MD 21044		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Baltimore-Washington Crematory	DATE: 7-1-95	20c. LOCATION — City or Town, State: Laurel, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] M00535		22. NAME AND ADDRESS OF FACILITY: Slack Funeral Home, PA. Ellicott City, MD 21043		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Pancreatic Cancer	1 year
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Liver Metastasis	2 months
DUE TO (OR AS A CONSEQUENCE OF):		
	c.	
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Nicholas W. Kourtesis MD	29c. LICENSE NUMBER: D38509	29d. DATE SIGNED (Month, Day, Year): July 1 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Nicholas W. Kourtesis MD 11065 Little Patuxent Pkwy Columbia MD 21044

31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: [signature] Gladys Marlow Randall

DHMH-16 Rev 1/89

95 20453

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Hazel Lee Newcomb			2. DATE OF DEATH (Month, Day, Year): July 5 1995	3. TIME OF DEATH: 2:00 A. M
4. SOCIAL SECURITY NUMBER: 225-26-1856	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 70 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Sept. 13, 1924	8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): 9906 Postwick Road		9b. CITY, TOWN OR LOCATION OF DEATH: Ellicott City		9c. COUNTY OF DEATH: Howard

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Howard	10c. CITY, TOWN OR LOCATION: Ellicott City	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 9906 Postwick Road	10f. ZIP CODE: 21042	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Peter Edward Woodruff		18. MOTHER'S NAME (First, Middle, Maiden Surname): Carrie Jane Bowen	
19a. INFORMANT'S NAME (Type/Print): Edward O. Newcomb, Sr. (Spouse)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9906 Postwick Road Ellicott City, Maryland 21042	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery DATE: July 7, 1995	20c. LOCATION — City or Town, State: Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: Leroy M & Russell C Witzke Funeral Homes 1630 Edmondson Avenue Catonsville Maryland		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ovarian cancer	1yr 9 months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☑ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

28. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☑ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D40850	29d. DATE SIGNED (Month, Day, Year): ▶ 7/5/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): YVONNE OTTAVIANO 900 CATON AVE BALTIMORE MD 21229

31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: [signature]

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DHMH-18 Rev 1/89

95 20454

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Joseph Neal
2. DATE OF DEATH (Month, Day, Year): July 3, 1995
3. TIME OF DEATH: 11:25 AM
4. SOCIAL SECURITY NUMBER: 217-14-7559
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 88 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 05-13-17
8. BIRTHPLACE (State or Foreign Country): UNK
9a. FACILITY NAME (If not institution, give street and number): SAINT AGNES HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH: N/A

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY: BALTO.
10c. CITY, TOWN OR LOCATION: CATONSVILLE
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 333 HARLEM LANE
10f. ZIP CODE: 21228
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: UNK (1 Never Married 2 Married 3 Widowed 4 Divorced)
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: UNK
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): UNK — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UNK
16b. KIND OF BUSINESS/INDUSTRY: UNL
17. FATHER'S NAME (First, Middle, Last): UNK
18. MOTHER'S NAME (First, Middle, Maiden Surname): UNK
19a. INFORMANT'S NAME (Type/Print): CARLA WARFIELD
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 861 PARK AVENUE BALTIMORE, MD. 21201
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): MT. ZION CEMETERY — DATE: 07-05-95
20c. LOCATION — City or Town, State: LANSDOWNE, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE:
22. NAME AND ADDRESS OF FACILITY: ALBERT P. WYLIE F/H PA, 638 N. GILMOR STREET 21217

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Sepsis due to osteomyelitis	1 month
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Anemia
Dementia

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D. Medical Resident
29c. LICENSE NUMBER: P 08860
29d. DATE SIGNED (Month, Day, Year): July 3, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 900 S. Caton Ave, Baltimore, MD 21229
31. DATE FILED (Month, Day, Year): JUL 06 1995
32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

FilmG, 725, item #1, 7/6/95,cyw, per f.h.

95 20455

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Alexandrina REMSEN Onderdonk			2. DATE OF DEATH (Month, Day, Year): July 5 1995	3. TIME OF DEATH: 12:40 am
4. SOCIAL SECURITY NUMBER: 216-03-6546	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 88 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Oct. 16, 1906	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Good Samaritan Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH: N/A

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: N/A	10c. CITY, TOWN OR LOCATION: Baltimore City	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1601 E. Belvedere Avenue		10f. ZIP CODE: 21239	10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 years; College (1-4 or 5+):	15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Office Manager	16b. KIND OF BUSINESS/INDUSTRY: Insurance Company	
17. FATHER'S NAME (First, Middle, Last): John Remsen Onderdonk		18. MOTHER'S NAME (First, Middle, Maiden Surname): Alexandrina Barton	
19a. INFORMANT'S NAME (Type/Print): Barbara O. Hare	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1710 Kennoway Road Baltimore, Maryland 21234		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Druid Ridge Cemetery; DATE: 7-8	20c. LOCATION — City or Town, State: Pikesville, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ George J Fenane	22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	septic shock	hours
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	pneumonia	days
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial fibrillation

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Jack Obeid MD		29c. LICENSE NUMBER: P08809	29d. DATE SIGNED (Month, Day, Year) ▶ July 5 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jack Obeid Good Samaritan Hospital / Loch Raven Blvd Baltimore MD 21239.			
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson Rodell		

DHMH-16 Rev 1/89

Item6 7-6-95 FilmG725 W.H.Per F/H

95 20456

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EDWARD REGINALD ODACHOWSKI					2. DATE OF DEATH (Month, Day, Year): July 1, 1995	3. TIME OF DEATH: 901 PM
4. SOCIAL SECURITY NUMBER: 217-38-3928	5. SEX: 1 X M 2 F	6. AGE (In yrs. last birthday): 54 ~~55~~ YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 01-04-1941	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): HARBOR HOSPITAL CENTER			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH: N/A	
RESIDENCE OF DECEDENT						
10a. STATE: MARYLAND	10b. COUNTY: ANNE ARUNDEL	10c. CITY, TOWN OR LOCATION: NORTH LINTHICUM			10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO	
10e. STREET AND NUMBER: 12 MANSION ROAD		10f. ZIP CODE: 21090			10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO IF YES, GIVE WAR OR DATES: KOREAN CONFLICT	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): TYPE SETTER			16b. KIND OF BUSINESS/INDUSTRY: PRINTING COMPANY	
17. FATHER'S NAME (First, Middle, Last): WALTER ODACHOWSKI					18. MOTHER'S NAME (First, Middle, Maiden Surname): STEPHANIE SOBODKA	
19a. INFORMANT'S NAME (Type/Print): CAROL A. ODACHOWSKI			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12 MANSION ROAD, NORTH LINTHICUM, MD. 21090			
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): HILLTOP SERVICES, INC. DATE: 7/6/1995			20c. LOCATION — City or Town, State: TOWSON, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]			22. NAME AND ADDRESS OF FACILITY: SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Congestive Cardiomyopathy	3 YRS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Diabetes Mellitus	10 yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Chronic Renal Failure	3 YRS
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. Diabetic Foot Ulcer	6 mos

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 X YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 X NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Richard A Baum MD

29c. LICENSE NUMBER: D 35526

29d. DATE SIGNED (Month, Day, Year) ▶ 7/3/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Richard A Baum MD 1600 Crain Hwy #507 Glen Burnie 21061

31. DATE FILED (Month, Day, Year): JUL 06 1995

32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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95 20457

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARGUERITE PIERCE		2. DATE OF DEATH (Month, Day, Year): JULY 03, 1995	3. TIME OF DEATH: 6:00 PM
4. SOCIAL SECURITY NUMBER: 226 32 8365	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 63 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): JAN 2, 1932
8. BIRTHPLACE (State or Foreign Country): VIRGINIA			
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY	9c. COUNTY OF DEATH: N/A	
RESIDENCE OF DECEDENT			
10a. STATE: MD	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: ROSEDALE	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 924 CHESACO AVENUE	10f. ZIP CODE: 21237	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CLAIMS AUTHORIZER	16b. KIND OF BUSINESS/INDUSTRY: FED. GOVERMENT SS	
17. FATHER'S NAME (First, Middle, Last): BRANSON FEATHERS	18. MOTHER'S NAME (First, Middle, Maiden Surname): MAY HERBAUGH		
19a. INFORMANT'S NAME (Type/Print): EARL E. PIERCE	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 924 CHESACO AVENUE ROSEDALE, MD 21237		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): HOLLY HILLS DATE: 7/5	20c. LOCATION — City or Town, State: BALTIMORE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTO, MD 21237		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	MULTI ORGAN FAILURE	14d
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST — b.	SEPSIS	30d
DUE TO (OR AS A CONSEQUENCE OF):		
c.	BUDD CHIARI	45d
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: HYPERTENSION

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Andrew J. McWhorter	M5878	JUL 3/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ANDREW MCWHORTER 600 WOLF STREET BALTIMORE MARYLAND 21287

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUL 06 1995	[signature]

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DHMH-16 Rev 1/89

95-3848-510
blh

95 20458

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Eloise B Perkins			2. DATE OF DEATH (Month, Day, Year): July 03 1995	3. TIME OF DEATH: 0308 M
4. SOCIAL SECURITY NUMBER: 577-36-5913	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 69 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Feb, 22, 1926	8. BIRTHPLACE (State or Foreign Country): South Carolina
9a. FACILITY NAME (If not institution, give street and number): 420 S. Parrish Street		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: N/A	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 420 S. Parrish Street		10f. ZIP CODE: 21223	10g. CITIZEN OF WHAT COUNTRY?: U.S

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+): N/A	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE	16b. KIND OF BUSINESS/INDUSTRY: HOME MAKER	
17. FATHER'S NAME (First, Middle, Last): BELTON DANZY		18. MOTHER'S NAME (First, Middle, Maiden Surname): JOANNA WASHINGTON	
19a. INFORMANT'S NAME (Type/Print): PEGGIE HAYES	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5257 Darien Rd Balto, Md 21206		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): MT. ZION	DATE: 7/8/95	20c. LOCATION — City or Town, State: LANDSDOWN MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph R Walters Jr.	22. NAME AND ADDRESS OF FACILITY: UNITY FUNERAL HOME 108 W. North Avenue Balto. Md 21201		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic Cardiovascular Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

24a. WAS AN AUTOPSY PERFORMED? ☒ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO	25. WAS CASE REFERRED TO MEDICAL EXAMINER? ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John Locke MD	29c. LICENSE NUMBER: O.C.M.E.	29d. DATE SIGNED (Month, Day, Year): July 03 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JLA RON LOCKE MD	111 Penn Street, Baltimore, Maryland 21201	
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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95-20459

FilmG, 725, item #16b, 7/6/95,cyw, per f.h.

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ALBERT LEROY PARDOE				2. DATE OF DEATH (Month, Day, Year): June 28, 1995	3. TIME OF DEATH: 10:10 AM
4. SOCIAL SECURITY NUMBER: 220-07-9121	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 82 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): July 9, 1912	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 3568 Horton Avenue 21225			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore (Brooklyn)		9c. COUNTY OF DEATH: NA

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: NA	10c. CITY, TOWN OR LOCATION: Baltimore (Brooklyn)		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3568 Horton Avenue		10f. ZIP CODE: 21225		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Retired Machinist	16b. KIND OF BUSINESS/INDUSTRY: Bethlehem Steel ~~Co~~ Corp.		
17. FATHER'S NAME (First, Middle, Last): James Wilbur Pardoe		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Mable Jones		
19a. INFORMANT'S NAME (Type/Print): Mrs. Florence M. Pardoe	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3568 Horton Ave., Baltimore, Md. 21225			
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Pk. DATE: 7/3/95	20c. LOCATION — City or Town, State: Glen Burnie, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Kevin E. Ecker	22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Anemia, Pancytopenia	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Bone Marrow Failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic Obstructive Pulmonary Disease with Asbestosis Osteo & Gout Arthritis

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Richard E. [illegible] MD	29c. LICENSE NUMBER: D02519	29d. DATE SIGNED (Month, Day, Year): 6-29-95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 4710 Pennington Ave., Balto., Md. 21226

31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: Julia Thweatt-Randall

DHMH-18 Rev 1/89

95 20460

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Donald G. Parlette			2. DATE OF DEATH (Month, Day, Year): June 29 1995	3. TIME OF DEATH: 3 P M
4. SOCIAL SECURITY NUMBER: 217-34-7089	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 63 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): March8,1932	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 6575 Rt. 32		9b. CITY, TOWN OR LOCATION OF DEATH: Clarksville	9c. COUNTY OF DEATH: Howard	
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Howard	10c. CITY, TOWN OR LOCATION: Clarksville	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO	
10e. STREET AND NUMBER: 6575 Rt. 32		10f. ZIP CODE: 21029	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Excavating	16b. KIND OF BUSINESS/INDUSTRY: Contractor		
17. FATHER'S NAME (First, Middle, Last): Jacob Parlette		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ruth Burgess		
19a. INFORMANT'S NAME (Type/Print): Sandra Parlette		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6575 Rt. 32 Clarksville Md. 21029		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Zion Cemetery DATE: 7-1-95	20c. LOCATION — City or Town, State: Clarksville, Md		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Allen Smith M00544	22. NAME AND ADDRESS OF FACILITY: Slack Funeral Home, P.A. Ellicott City, Md. 21043			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Lung Cancer to the Liver and Brain	8months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☒ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Nicholas Koutrelakos	D38509	▶ June 30th 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Nicholas Koutrelakos 11065 Little Patuxent Pkwy Columbia Md 21044

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUL 0 6 1995	Julie Madden Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20

95 20461

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARY ELIZABETH PARKS			2. DATE OF DEATH (Month, Day, Year): JULY 3, 1995	3. TIME OF DEATH: 7:25 P. M
4. SOCIAL SECURITY NUMBER: 220-14-5932	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 86 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Sept. 23, 1908	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Meridian Nursing Center		9b. CITY, TOWN OR LOCATION OF DEATH: Severna Park		9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Pasadena	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1604 S. Shore Parkway		10f. ZIP CODE: 21122	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ ND Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): --	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerical	16b. KIND OF BUSINESS/INDUSTRY: B&O-CSX Railroad	
17. FATHER'S NAME (First, Middle, Last): Jasper Galvin		18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Schlesinger	
19a. INFORMANT'S NAME (Type/Print): Mr. Charles W. Parks		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1604 S. Shore ParkwAy Pasadena, MD. 21122	
20. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery/crematory or other place): London Park Cemetery	DATE: 7/7/95	20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Valerie S. Polyniak		22. NAME AND ADDRESS OF FACILITY: Mc Cully Funeral Home of Pasadena 3204 Mountain Road Pasadena, MD. 21122	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cerebrovascular Accident	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Hypertension	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Adult onset diabetes	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Multi-infarct dementia

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☑ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ ND	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: 04927	29d. DATE SIGNED (Month, Day, Year) ▶ 7/5/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PEREZ-ALAD, MD 3708 MOUNTAIN RD Pasadena, MD 21122		
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: Julia Brutsos Randall	

DHMH-18 Rev 1/89

95 20462

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARTHA THERESA RAY			2. DATE OF DEATH: July 5 1995	3. TIME OF DEATH: 2:00p. M
4. SOCIAL SECURITY NUMBER: 212-32-7695	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 59 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Dec 9, 1935	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Stella Maris Hospice		9b. CITY, TOWN OR LOCATION OF DEATH: Towson		9c. COUNTY OF DEATH: Maryland

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 8061 Wallace Road		10f. ZIP CODE: 21222	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Private Secretary	16b. KIND OF BUSINESS/INDUSTRY: Kaufman & Applefeld Attorney	
17. FATHER'S NAME (First, Middle, Last): Joseph E. Laumann		18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Cragnelli	
19a. INFORMANT'S NAME (Type/Print): Nelson Ray, Sr.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8061 Wallace Road Baltimore, Maryland 21222	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Memorial Park	DATE: 7/7/95	20c. LOCATION — City or Town, State: Elkridge, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ A. Alan Seitz Jr		22. NAME AND ADDRESS OF FACILITY: A. Alan Seitz, Jr. Funeral Home 3818 Roland Ave. Baltimore, Maryland 21211	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. BREAST CANCER — 2yrs.

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Kendall R Faulkner MD	29c. LICENSE NUMBER: D25243	29d. DATE SIGNED (Month, Day, Year): ▶ 7/5/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Kendall Faulkner, 2300 Dulaney Valley Rd. Towson, MD 21204

31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR: John Wesley Forsythe

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 20463

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Minna Roll				2. DATE OF DEATH (Month, Day, Year): JUNE 29 95	3. TIME OF DEATH: 115 A M
4. SOCIAL SECURITY NUMBER: 212-36-8745	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 94 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): FEB. 8, 1901
8. BIRTHPLACE (State or Foreign Country): RUSSIA					
9a. FACILITY NAME (If not institution, give street and number): NORTHWEST HOSPITAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: RANDALLSTOWN		9c. COUNTY OF DEATH: BALTIMORE	
RESIDENCE OF DECEDENT					
10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: BALTIMORE		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO	
10e. STREET AND NUMBER: 4204 MILFORD MILL ROAD		10f. ZIP CODE: 21208		10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY: OWN HOME	
17. FATHER'S NAME (First, Middle, Last): ISIDORE TALLESNIK		18. MOTHER'S NAME (First, Middle, Maiden Surname): EVA LIEBERMAN			
19a. INFORMANT'S NAME (Type/Print): MR. ARTHUR DRAGER, ESQ.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5 LIGHT STREET, SUITE 510 BALTIMORE, MD 21202			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): TIFERETH ISRAEL ANSHE SFARD	DATE: 6-30-1995	20c. LOCATION — City or Town, State: ROSEDALE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Scott M. Attle		22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pneumonia	NINE
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): b. Lung Cancer	DAYS
	DUE TO (OR AS A CONSEQUENCE OF): c.	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Congestive Heart Failure

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☑

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Heeger MD	29c. LICENSE NUMBER: D43750	29d. DATE SIGNED (Month, Day, Year): 6/29/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): HENRY OSEI NORTHWEST HOSPITAL CENTER		
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: Jabi Mendoza-Randall	

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DHMH-16 Rev 1/89

Rosenthal, Martin 1900 7/3/95-
Item12 7-6-95 FilmG725 W.H.Per F/H 95 20464

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARTIN ROSENTHAL			2. DATE OF DEATH: MONTH JULY DAY 3, YEAR 1995	3. TIME OF DEATH: 7 pM M
4. SOCIAL SECURITY NUMBER: 215-10-4709	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 80 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.	7. DATE OF BIRTH (Month, Day, Year): OCT. 7, 1914	8. BIRTHPLACE (State or Foreign Country): PENNSYLVANIA
9a. FACILITY NAME (If not institution, give street and number): WASHINGTON COUNTY HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: HAGERSTOWN		9c. COUNTY OF DEATH: WASHINGTON

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: WASHINGTON	10c. CITY, TOWN OR LOCATION: HAGERSTOWN	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 502 D LYNNEHAVEN DRIVE		10f. ZIP CODE: 21742	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: Navy WWII ~~ARMY~~	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 1	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MERCHANT	16b. KIND OF BUSINESS/INDUSTRY: HARDWARE
17. FATHER'S NAME (First, Middle, Last): SOL ROSENTHAL		18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNA UNKNOWN	
19a. INFORMANT'S NAME (Type/Print): DR. JOEL ROSENTHAL		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 19806 SPRING CREEK ROAD HAGERSTOWN, MD 21742	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place): BETH TFILOH — DATE: 7-5-1995	20c. LOCATION — City or Town, State: BALTIMORE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Allan Levinson		22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Acute myelogenous leukemia	1 month
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	myelodysplastic syndrome	6 months
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D23623	29d. DATE SIGNED (Month, Day, Year) ▶ 7/3/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Frederic H. Glass III MD 1799 Howell Rd Hagerstown md

31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

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DHMH-18 Rev 1/89

95 20465

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GEORGE G. RUMPLE			2. DATE OF DEATH (Month, Day, Year): JULY 3 1995	3. TIME OF DEATH: 9:30 PM
4. SOCIAL SECURITY NUMBER: 239 26 2800	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 71 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): SEPT 24 23
8. BIRTHPLACE (State or Foreign Country): N. Carolina				
9a. FACILITY NAME (If not institution, give street and number): ER FALLSTON GLEN HOSP	9b. CITY, TOWN OR LOCATION OF DEATH: FALLSTON	9c. COUNTY OF DEATH: HARFORD		

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10a. STREET AND NUMBER: 3444 LOGAN VIEW DR		10f. ZIP CODE: 21222	10g. CITIZEN OF WHAT COUNTRY? USA.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Engineer	16b. KIND OF BUSINESS/INDUSTRY: Railroad	
17. FATHER'S NAME (First, Middle, Last): William Rumple		18. MOTHER'S NAME (First, Middle, Maiden Surname): Hattie Armstrong	
19a. INFORMANT'S NAME (Type/Print): Thelma Rumple	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3444 Logan View Dr. Baltimore, Md 21222		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, cramatory or other place): Bel Air Memorial	DATE: 7-8	20c. LOCATION — City or Town, State: Bel Air, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Anthony Colt	22. NAME AND ADDRESS OF FACILITY: Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. ACUTE CORONARY ARTERY DISEASE
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. A S W D.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
S P M I.
CARDIAC ARRYTHMIA

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): NA	28b. TIME OF INJURY: NA M	28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO
28d. DESCRIBE HOW INJURY OCCURED: NA			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): NA	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): NA		

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: DME	29c. LICENSE NUMBER: D21809	29d. DATE SIGNED (Month, Day, Year): ▶ 7-3 95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): G PRABHU M.D 1810 BELAIR RD FALLSTON MD 21047. 879-6564.			
31. DATE FILED (Month, Day, Year): JUL 06 1995	REGISTRAR'S SIGNATURE: Julie		

OHMH-16 Rev 1/89

10

95 20466

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JAMES T. SHERIDAN			2. DATE OF DEATH (Month, Day, Year): JULY 1 1995	3. TIME OF DEATH: 5-09P M
4. SOCIAL SECURITY NUMBER: 213-34-6186	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 58 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): DEC 25, 36	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): ER FALLSTON GEN. HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: FALLSTON	9c. COUNTY OF DEATH: HARFORD	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: HARFORD	10c. CITY, TOWN OR LOCATION: FALLSTON	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1214 HILLSBORO COURT		10f. ZIP CODE: 21047	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12YRS. College (1-4 or 5+): 6YRS.	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ESTATE + GIFT PLANNING	16b. KIND OF BUSINESS/INDUSTRY: FED. GOV'T - I.R.S. FEDERAL GOV'T	
17. FATHER'S NAME (First, Middle, Last): WILLIAM SHERIDAN		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARTHA BROWN	
19a. INFORMANT'S NAME (Type/Print): IRENE D. SHERIDAN		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1214 HILLSBORO COURT FALLSTON, MARYLAND 21047	
20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place): HIGHVIEW MEMORIAL	DATE: 7-5-95	20c. LOCATION — City or Town, State: FALLSTON, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: EVANS FUNERAL CHAPEL — BEL AIR, MD. 21050 3 NEWPORT DRIVE FOREST HILL, MD.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. PNEUMONIA	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. COPD.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

S/P SEPTIC ARTHRITIS (R) HIP
RHEUMATOID ARTHRITIS.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): NA	28b. TIME OF INJURY: NA M	28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO	28d. DESCRIBE HOW INJURY OCCURED: NA
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): NA			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): NA

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] OME	29c. LICENSE NUMBER: D21809	29d. DATE SIGNED (Month, Day, Year): JULY 1 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): G PRASAD MD 1810 BELAIR RD FALLSTON MD 21047 879-6564.		
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: [signature] Deputy Registrar	

DHMH-16 Rev 1/89

95 20467

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): STANLEY O. SCHAUB, JR.
2. DATE OF DEATH — MONTH: JULY DAY: 2 YEAR: 1995
3. TIME OF DEATH: 2:40 A M
4. SOCIAL SECURITY NUMBER: 212-20-0198
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 69 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): OCT. 17, 1925
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): 1812 TWIN OAK ROAD
9b. CITY, TOWN OR LOCATION OF DEATH: JARRETTSVILLE
9c. COUNTY OF DEATH: HARFORD

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: HARFORD
10c. CITY, TOWN OR LOCATION: JARRETTSVILLE
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1812 TWIN OAK ROAD
10f. ZIP CODE: 21084
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: W.W.II
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 YRS. — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MECHANIC HELPER
16b. KIND OF BUSINESS/INDUSTRY: BETHLEHEM STEEL CORP.
17. FATHER'S NAME (First, Middle, Last): STANLEY O. SCHAUB, SR.
18. MOTHER'S NAME (First, Middle, Maiden Surname): LORETTA BRADEN
19a. INFORMANT'S NAME (Type/Print): GLORIA SCHAUB
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1812 TWIN OAK ROAD JARRETTSVILLE, MARYLAND 21084
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): FAIRWOOD CEMETERY — DATE: 7-5-95
20c. LOCATION — City or Town, State: PARKVILLE, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: EVANS FUNERAL CHAPEL — BEL AIR, P.A. 21050 — 3 NEWPORT DRIVE FOREST HILL, MARYLAND

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. METASTATIC Non Small Cell Lung CA	2 YRS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [X] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. LICENSE NUMBER: D33551
29d. DATE SIGNED (Month, Day, Year): JULY 3, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR MICHAEL AUERBACH 9000 FRANKLIN SQUARE DRIVE

31. DATE FILED (Month, Day, Year): JUL 06 1995
32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

95 20468

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DAVID Scott
2. DATE OF DEATH (Month, Day, Year): June 29, 1995
3. TIME OF DEATH: 2:45A M
4. SOCIAL SECURITY NUMBER: 218-64-2357
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 39 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): Jan 14, 1956
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Seton Hill Manor
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: N/A

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: N/A
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2015 Etting Street
10f. ZIP CODE: 21217
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th grade; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Steel Worker
16b. KIND OF BUSINESS/INDUSTRY: Bethlehem Steel
17. FATHER'S NAME (First, Middle, Last): Clarence Scott, Jr.
18. MOTHER'S NAME (First, Middle, Maiden Surname): Laura Mae Cheatham
19a. INFORMANT'S NAME (Type/Print): Acquaretta Marshall
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2015 Etting Street Baltimore, Md 21217
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Zion Cemetery DATE: 7/6/95
20c. LOCATION — City or Town, State: Baltimore Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Leroy Harris
22. NAME AND ADDRESS OF FACILITY: 3240 Reisterstown Road Chatman-Harris F.H. Baltimore Md 21215

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Acquired Immunodeficiency Syndrome	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.		
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: MALNUTRITION, Cachexia

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: DSSalvo
29c. LICENSE NUMBER: D17537
29d. DATE SIGNED (Month, Day, Year): 7.5.95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DARSHAN S. SALUJA MD 1600 W. MOUNT ROYAL Ave, Balto 21217
31. DATE FILED (Month, Day, Year): JUL 06 1995
32. REGISTRAR'S SIGNATURE: Julie Davidson Randall

DHMH-16 Rev 1/89

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95 20469

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Evelyn E.Seiler
2. DATE OF DEATH (Month, Day, Year): June 30,1995
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 213-10-8646
5. SEX: 1 ☐ M 2 ☒ F (X)
6. AGE (In yrs. last birthday): 76 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Dec.7,1918
8. BIRTHPLACE (State or Foreign Country): England
9a. FACILITY NAME (If not institution, give street and number): Atlantic Gen.Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Berlin, Md.
9c. COUNTY OF DEATH: Worchester Co.

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: none
10c. CITY, TOWN OR LOCATION: Balto.City,Md.
10d. INSIDE CITY LIMITS? 1 ☒ YES (XX) 2 ☐ NO
10e. STREET AND NUMBER: 527 E.Clement St.
10f. ZIP CODE: 21230
10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed (XX) 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO (X) IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO (X) Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th.Grade — College (1-4 or 5+): none
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary
16b. KIND OF BUSINESS/INDUSTRY: McCormick Co.
17. FATHER'S NAME (First, Middle, Last): Walter Payne
18. MOTHER'S NAME (First, Middle, Maiden Surname): Evelyn Householder
19a. INFORMANT'S NAME (Type/Print): Mrs.Evelyn Johnson
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7649 Marcy Ct. Glen Burnie,Md.21060
20a. METHOD OF DISPOSITION: 1 ☒ Burial (X) 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place): Meadowridge Mem.Park — DATE: 7/3/95
20c. LOCATION — City or Town, State: Elkridge,Howard Co. Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home,130 E.Fort Ave. Balto.Md.21230

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. acute MI — 4 days
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. anoxic encephalopathy
DUE TO (OR AS A CONSEQUENCE OF):
c. sepsis
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO (X)
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO (X)
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO (X)
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient (X) 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural (X) 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. LICENSE NUMBER: RB4119966
29d. DATE SIGNED (Month, Day, Year): 6/30/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jonathon Beer MD Atlantic Gen. Hosp Berlin MD 21811
31. DATE FILED (Month, Day, Year): JUL 06 1995
32. REGISTRAR'S SIGNATURE: [signature]

DNMN-16 Rev 1/89

95 20470

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARION OLIVER SHANE			2. DATE OF DEATH (Month, Day, Year): July 4, 1995	3. TIME OF DEATH: 3:55 P M
4. SOCIAL SECURITY NUMBER: 212-03-4103	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 86 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Dec. 29, 1908	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Masonic Home of Maryland		9b. CITY, TOWN OR LOCATION OF DEATH: Cockeysville		9c. COUNTY OF DEATH: Baltimore County

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore County	10c. CITY, TOWN OR LOCATION: Cockeysville	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 300 International Circle		10f. ZIP CODE: 21030	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4 yrs	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Engineering Analyst	16b. KIND OF BUSINESS/INDUSTRY: Aerospace Production
17. FATHER'S NAME (First, Middle, Last): Francis Marion Shane		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Virginia Oliver	
19a. INFORMANT'S NAME (Type/Print): Mrs. Edith L. Shane		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1828 Aberdeen Road, Baltimore, Maryland 21234	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Green Mount Crematory DATE: 7/6	20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Martin D. Lawson		22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home 6500 York Road, Baltimore, Maryland 21212	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or reapiratory arrest, shock, or heart feilure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition resulting in death) →	a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF):	3d
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CVA

arrythmia

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: June Breiner MD	29c. LICENSE NUMBER: D40208	29d. DATE SIGNED (Month, Day, Year): 7/5/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Junne Breiner, M.D., 1205 York Road, Lutherville, MD 21093

31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: Libi Gardner Rodell

DHMH-18 Rev 1/89

Item20c 7-6-95 FilmG725 W.H.Per F/H

95 20471

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): SADIE MARIE SIMMONS		2. DATE OF DEATH: MONTH July DAY 2 YEAR 95	3. TIME OF DEATH: 2230 M
4. SOCIAL SECURITY NUMBER: 219-30-9074	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 88 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country): Baltimore, Md.
9a. FACILITY NAME (If not institution, give street and number): Saint Agnes Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, Md.	9c. COUNTY OF DEATH: N / A

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: N / A	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 802 Lyndhurst Street		10f. ZIP CODE: 21229	10g. CITIZEN OF WHAT COUNTRY? U S A

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th; College (1-4 or 5+): N /A	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Domestic	16b. KIND OF BUSINESS/INDUSTRY: Unknown	
17. FATHER'S NAME (First, Middle, Last): William Simmons		18. MOTHER'S NAME (First, Middle, Maiden Surname): Cora Makel	
19a. INFORMANT'S NAME (Type/Print): Lenora Isiah Weathers		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 802 Lyndhurst ST.,Baltimore,Md.21229	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus DATE 7-7	20c. LOCATION — City or Town, State: Baltimore, ~~Baltimore~~,Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶		22. NAME AND ADDRESS OF FACILITY: Carlton C.Douglass 1701 McCullohSt. Balto.,Md.21217	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not entar the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only ona cause on aach line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Uro Sepsis DUE TO (OR AS A CONSEQUENCE OF):	1 day
Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. CVA DUE TO (OR AS A CONSEQUENCE OF):	1 yr.
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD		29c. LICENSE NUMBER: D21925	29d. DATE SIGNED (Month, Day, Year) ▶ 7/3/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 1101 Maiden Choice Lane Balt. MD 21225			
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall		

DHMH-16 Rev 1/89

4

Baltimore.

RKD

95-3763-005

95 20472

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-725 7/19/95 t.t

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): THELMA Marie SETTERS			2. DATE OF DEATH (Month, Day, Year): JUNE 27 95	3. TIME OF DEATH: 8:55 A.M
4. SOCIAL SECURITY NUMBER: 216-36-0544	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 56 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): April 12, 1939	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 2027 frames ROAD		9b. CITY, TOWN OR LOCATION OF DEATH: DUNDALK		9c. COUNTY OF DEATH: BALTIMORE
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: A.A.Co.	10c. CITY, TOWN OR LOCATION: Brooklyn Md.		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 307 Hillcrest Ave.		10f. ZIP CODE: 21225		10g. CITIZEN OF WHAT COUNTRY? United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th.Grade; College (1-4 or 5 +): None		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Waitress		16b. KIND OF BUSINESS/INDUSTRY: Restaurant
17. FATHER'S NAME (First, Middle, Last): Melvin E. Browning		18. MOTHER'S NAME (First, Middle, Maiden Surname): Thelma M. Metzler		
19a. INFORMANT'S NAME (Type/Print): Mrs.Thelma M.Browning		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1115 S.Hanover St.Balto.Md.21230		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery, DATE: 6/30/95		20c. LOCATION — City or Town, State: Balto.Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Eugene J. Lastner Jr.		22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home, 130 E.Fort Ave. Balto.Md.21230		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. SMOKE INHALATION	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☒ Could not be determined

28a. DATE OF INJURY (Month, Day, Year): FOUND ON 6/27/95
28b. TIME OF INJURY: FOUND AT 6:45 AM
28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO
28d. DESCRIBE HOW INJURY OCCURED: UNKNOWN
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): FOUND AT HOME
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 2027 FRAMES ROAD DUNDALK, MARYLAND

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: O.C.M.E.
29d. DATE SIGNED (Month, Day, Year): JUNE 28, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DAVID R FOWLER 111 Penn Street, Baltimore, Maryland 21201

31. DATE FILED (Month, Day, Year): JUL 06 1995
32. REGISTRAR: [signature]

DHMH-16 Rev 1/89

95 20473

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Margaret Lucille Smith			2. DATE OF DEATH: Month July, Day 2, Year 1995	3. TIME OF DEATH: 3:20 AM M
4. SOCIAL SECURITY NUMBER: 219-01-9580	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 82 YRS.	IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.	7. DATE OF BIRTH (Month, Day, Year): July 14, 1912
8. BIRTHPLACE (State or Foreign Country): Maryland				
9a. FACILITY NAME (If not institution, give street and number): Heritage Meridian Nursing Home	9b. CITY, TOWN OR LOCATION OF DEATH: Dundalk	9c. COUNTY OF DEATH: Baltimore		
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Dundalk	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO	
10e. STREET AND NUMBER: 2816 Creston Road	10f. ZIP CODE: 21222	10g. CITIZEN OF WHAT COUNTRY? United States		
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY: Own Home		
17. FATHER'S NAME (First, Middle, Last): Burtrum Bateman	18. MOTHER'S NAME (First, Middle, Maiden Surname): Aloysins Brooks			
19a. INFORMANT'S NAME (Type/Print): Milton S. Smith	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2816 Creston Road Dundalk, Maryland 21222			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cemetery 7/5/95	DATE	20c. LOCATION — City or Town, State: Parkville, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶	22. NAME AND ADDRESS OF FACILITY: Duda - Ruck Funeral Home, Inc. 7922 Wise Ave. Dundalk, Maryland 21222			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Ischemic Cardiomyopathy	Months
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF): Arteriosclerotic Heart Disease	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶
[signature] M.D.	D08358	7/3/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Grace to V. Patrick M.D.

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUL 06 1995	Julia Brookes Randall

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DHMH-18 Rev 1/89

95 20474

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CHARLES L. SHUMAN
2. DATE OF DEATH — MONTH: July DAY: 2 YEAR: 95
3. TIME OF DEATH: 5:45 AM
4. SOCIAL SECURITY NUMBER: 214-24-9417
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 88 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): NOV. 10, 1906
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): LEVINDALE
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH: N/A

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: N/A
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 7301 PARK HEIGHTS AVE, APT. 308
10f. ZIP CODE: 21208
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4 or 5+): 5+
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ATTORNEY
16b. KIND OF BUSINESS/INDUSTRY: LAW
17. FATHER'S NAME (First, Middle, Last): ISAAC SHUMAN
18. MOTHER'S NAME (First, Middle, Maiden Surname): REBECCA LOWENTHAL
19a. INFORMANT'S NAME (Type/Print): MRS. LORAINE K. SHUMAN
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7301 PARK HEIGHTS AVE, APT. 308 BALTIMORE, MD 21208
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place): ARLINGTON - CHIZUK AMUNO — DATE: 7-3-1995
20c. LOCATION — City or Town, State: BALTIMORE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. PROSTATE CARCINOMA	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Anemia 2° chronic Disease Renal Failure

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Howard B. Rubin M.D.
29c. LICENSE NUMBER: D21680
29d. DATE SIGNED (Month, Day, Year): 7/2/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): HOWARD B. RUBIN, M.D. 6717 PARK HEIGHTS AVE 21215
31. DATE FILED (Month, Day, Year): JUL 06 1995
32. REGISTRAR'S SIGNATURE

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OHMH-16 Rev 1/89

Item17,Film725,7/7/95,1t

95 20475

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ANNA SZYMANSKI		2. DATE OF DEATH (Month, Day, Year): JULY 2 1995	3. TIME OF DEATH: 10:00A. M
4. SOCIAL SECURITY NUMBER: 212-26-2078	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 87 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 2/14/08
8. BIRTHPLACE (State or Foreign Country): RUSSIA-POLAND			
9a. FACILITY NAME (If not institution, give street and number): MERIDIAN N.H. - PERRING PARKWAY	9b. CITY, TOWN OR LOCATION OF DEATH: PARKVILLE	9c. COUNTY OF DEATH: BALTIMORE	
RESIDENCE OF DECEDENT			
10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: TOWSON	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 8618 DRUMWOOD ROAD	10f. ZIP CODE: 21286	10g. CITIZEN OF WHAT COUNTRY: USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6th GRADE; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SEAMSTRESS	16b. KIND OF BUSINESS/INDUSTRY: CLOTHING MANUFACTURER	
17. FATHER'S NAME (First, Middle, Last): THEODORE ~~ROWELL~~ KOWELL	18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNA HOMLACH		
19a. INFORMANT'S NAME (Type/Print): HELEN JAGODZINSKI	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8618 DRUMWOOD ROAD BALTIMORE, MD 21286		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place): METRO CREMATORY, INC. DATE: 7/3/95	20c. LOCATION — City or Town, State: CATONSVILLE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Christia A. Kopczyk	22. NAME AND ADDRESS OF FACILITY: JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Ca of lungs	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Ischemic Heart Disease

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☑

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D085588	29d. DATE SIGNED (Month, Day, Year) ▶ 7/5/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): GRACITO V. PATRICIO 8903 HARFORD ROAD BALTIMORE, MD		
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall	

DHMH-18 Rev 1/89

95 20476

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ethel Cora Schaefer			2. DATE OF DEATH (Month, Day, Year): July 2 1995	3. TIME OF DEATH: 2:24 P M
4. SOCIAL SECURITY NUMBER: 178-10-9198	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 90 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Dec. 21, 1904	8. BIRTHPLACE (State or Foreign Country): Pa.
9a. FACILITY NAME (If not institution, give street and number): Northwest Hospital Center		9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown		9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Reisterstown	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 29 W. Chestnut Hill Ln. Apt. A-7		10f. ZIP CODE: 21136	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Bookkeeper	16b. KIND OF BUSINESS/INDUSTRY: Accounting	
17. FATHER'S NAME (First, Middle, Last): John William DeWire		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mae Aunkst	
19a. INFORMANT'S NAME (Type/Print): Paul E. Miller	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 217 Landis Ave. Waynesboro, Pa. 17268		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Carroll Cremation DATE: 7-3-95	20c. LOCATION — City or Town, State: Hampstead, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Frank B Eline	22. NAME AND ADDRESS OF FACILITY: 11824 Reisterstown Road Eline Funeral Home Reisterstown, Md. 21136		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Probable Myocardial infarct DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Steven Smith MD	29c. LICENSE NUMBER: D 28304	29d. DATE SIGNED (Month, Day, Year): 7/3/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 750 Main St Reisterstown MD 21136

31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: Julie Strickler Kerbel

DHMH-16 Rev 1/89

Items7,10g,13 7-6-95 FilmG725 W.H.Per F/H

95 20477

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): IRENE SHAKHNOUSKY

2. DATE OF DEATH (Month, Day, Year): JULY 01 1995

3. TIME OF DEATH: 10 45 (A M)

4. SOCIAL SECURITY NUMBER: 220-23-4859

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 70 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): ~~SEPT~~ Sept 25, 1924

8. BIRTHPLACE (State or Foreign Country): RUSSIA

9a. FACILITY NAME (If not institution, give street and number): NORTHWEST HOSPITAL CENTER

9b. CITY, TOWN OR LOCATION OF DEATH: RANDALLSTOWN

9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND

10b. COUNTY: N/A

10c. CITY, TOWN OR LOCATION: BALTIMORE

10d. INSIDE CITY LIMITS? X 1 ☐ YES 2 ☐ NO

10e. STREET AND NUMBER: 3615 FORDS LA. APT. 302

10f. ZIP CODE: 21215

10g. CITIZEN OF WHAT COUNTRY? ~~USA~~ Unknown

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
~~X~~ 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4 or 5 +): 4

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): BOOKKEPER

16b. KIND OF BUSINESS/INDUSTRY: SALES

17. FATHER'S NAME (First, Middle, Last): HANNAH BOTVINSKY

18. MOTHER'S NAME (First, Middle, Maiden Surname): FRIDA UNKNOWN

19a. INFORMANT'S NAME (Type/Print): BELLA RUSSIN

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6807 PARK HEIGHTS AVE., APT. T-2 BALTO., MD 21215

20a. METHOD OF DISPOSITION: X 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): ARLINGTON (CHIZUK AMUNO) DATE: 7/3/95

20c. LOCATION — City or Town, State: BALTIMORE, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Scott M. Cattle

22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	PANCREATIC CANCER WITH METASTASIS TO LIVER	> 2 MONTHS
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.		
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: K.S. RAO M.D

29c. LICENSE NUMBER: D43462

29d. DATE SIGNED (Month, Day, Year): JULY 1st 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): K.S. RAO M.D NORTHWEST HOSPITAL CENTER. RANDALLSTOWN MD

31. DATE FILED (Month, Day, Year): JUL 06 1995

32. REGISTRAR'S SIGNATURE: Julia Llewellyn Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2

95 20478

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DAVID STOKES-CLAYTON			2. DATE OF DEATH (Month, Day, Year): JUNE 03 1995	3. TIME OF DEATH: 3:00 A M
4. SOCIAL SECURITY NUMBER	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday) YRS. / IF UNDER 1 YEAR: MONTHS, DAYS / IF UNDER 24 HRS.: HOURS, MIN.	7. DATE OF BIRTH (Month, Day, Year): June 3, 95	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): MARYLAND GENERAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE	9c. COUNTY OF DEATH	

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?	

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5 +)	15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): David O. Clayton		18. MOTHER'S NAME (First, Middle, Maiden Surname): Latoya Eunice Stokes
19a. INFORMANT'S NAME (Type/Print): Latoya Eunice STokes	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 423 Trimble Fields Dr., Edgewood, MD 21040	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) / DATE	20c. LOCATION — City or Town, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald Wade, Dir.	22. NAME AND ADDRESS OF FACILITY: State Anatomy Board 655 W. Baltimore St., Balto., MD 21201	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. EXTREME PREMATURITY	1hr 30min
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [X]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D13669	29d. DATE SIGNED (Month, Day, Year): ▶ JUNE 03 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DURGADAS KULKARNI, MD C/O MARYLAND GENERAL HOSPITAL 827 LINDEN AVE		
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: Rebecca Randall	

DHMH-16 Rev 1/89

95 20479

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ELIZABETH L SMARR			2. DATE OF DEATH (Month, Day, Year): July 2 1995	3. TIME OF DEATH: 9.42 PM
4. SOCIAL SECURITY NUMBER: 214 40 7573	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 94 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Jan. 10, 1901	8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): Northwest Hospital Center		9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown		9c. COUNTY OF DEATH: Baltimore
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY: Carroll	10c. CITY, TOWN OR LOCATION: Sykesville		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 7200 Third Ave.		10f. ZIP CODE: 21784		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): High School; College (1-4 or 5+): #4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher		16b. KIND OF BUSINESS/INDUSTRY: Sc hool
17. FATHER'S NAME (First, Middle, Last): William James Smarr		18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret Wg. Wagner		
19a. INFORMANT'S NAME (Type/Print): Fairhaven Retirement Center		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7200 Third Ave. Sykesville, Md. 21784		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cemetery DATE: 7/5/95		20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Harry W. Haight		22. NAME AND ADDRESS OF FACILITY: Haight Funeral Home P.O.Box 195 Sykesville, Md. 21784		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Sepsis	3 days
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: Renal failure

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M Mallhavey MD

29c. LICENSE NUMBER: D-40521

29d. DATE SIGNED (Month, Day, Year): ▶ July 2, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MAHESH S. OCHANEY, M.D. NORTHWEST HOSPITAL CENTER 5401 OLD COURT ROAD, RANDALLSTOWN, MD 21133

31. DATE FILED (Month, Day, Year): JUL 06 1995

32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

95 20480

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mary E. Tolson			2. DATE OF DEATH (Month, Day, Year): July 1, 1995	3. TIME OF DEATH: 11:30 P.M
4. SOCIAL SECURITY NUMBER: 215-16-5509	5. SEX: 1 ☐ M 2 XX F	6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Aug. 28, 1918	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 2048 Kurtz Ave.		9b. CITY, TOWN OR LOCATION OF DEATH: Pasadena, Md.		9c. COUNTY OF DEATH: A.A.Co.Md.
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: A.A.Co.	10c. CITY, TOWN OR LOCATION: Pasadena, Md.		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 2048 Kurtz Ave.		10f. ZIP CODE: 21122		10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: Sept. (1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced)	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES X	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: X		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 8th.Grade; College (1-4 or 5+): none	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Waitress	16b. KIND OF BUSINESS/INDUSTRY: White Coffee Pot		
17. FATHER'S NAME (First, Middle, Last): George A. Winterling		18. MOTHER'S NAME (First, Middle, Maiden Surname): Lillian E. Lowe		
19a. INFORMANT'S NAME (Type/Print): Montana Karasek	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2048 Kurtz Ave. Pasadena, Md. 21122			
20a. METHOD OF DISPOSITION: X 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Holy Cross Cemetery DATE: 7/5/95	20c. LOCATION — City or Town, State: Brooklyn, Md.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Montana Karasek	22. NAME AND ADDRESS OF FACILITY: Balto.Md. 21230 McCully Funeral Home, 130 E. Fort Ave.			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. End Stage Emphysema	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
	D41977	▶ 7/3/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jorge Perez-MD 3708 Mountain Road Pasadena, MD 21122

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUL 06 1995	

5

DHMH-16 Rev 1/89

ITEMS: 27, 28a-f, PER MEO FILM G-726 8/24/95 t.t

95 20481

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Alice L. Thompson			2. DATE OF DEATH (Month, Day, Year): 07 03 95	3. TIME OF DEATH: 1:44p M
4. SOCIAL SECURITY NUMBER: 220-38-8854	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 50 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): July 14, 1944
8. BIRTHPLACE (State or Foreign Country): Maryland				
9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Med.	9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore	9c. COUNTY OF DEATH: N/A		

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: N/A	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 2000 Odell Ave. Apt. 1606	10f. ZIP CODE: 21237	10g. CITIZEN OF WHAT COUNTRY? USA	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10	College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home

17. FATHER'S NAME (First, Middle, Last): John T. Brown	18. MOTHER'S NAME (First, Middle, Maiden Surname): Evelyn Nance
19a. INFORMANT'S NAME (Type/Print): Evelyn Giddings	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4311 Fairview Ave. Balto. Md. 21216

20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): King Memorial	DATE: 7/6/95	20c. LOCATION — City or Town, State: Balto. Co. Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Joseph L. Russ	22. NAME AND ADDRESS OF FACILITY: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Sepsis	3 days
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Cardiac arrhythmia	1 day
DUE TO (OR AS A CONSEQUENCE OF):		
c.	hypothermia	1 day
DUE TO (OR AS A CONSEQUENCE OF):		
d.	alcohol abuse	1 day

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☑ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) FOUND: JULY 1, 1995	28b. TIME OF INJURY: UNKNOWN M	28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO	28d. DESCRIBE HOW INJURY OCCURED: COLLAPSED IN FRONT OF OPEN REFRIGERATOR
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): HOME			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): SAME AS #10

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Noah Lechtzin, MD	29c. LICENSE NUMBER: M6316	29d. DATE SIGNED (Month, Day, Year) ▶ 7/3/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Noah Lechtzin, Johns Hopkins Hospital, Tower 110, 600 N. Wolfe, Balt, MD 21287		
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: [signature]	

DHMH-16 Rev 1/89

95 20482

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Jesse Trammell SR			2. DATE OF DEATH (Month / Day / Year): July 3 1995	3. TIME OF DEATH: 8:24 AM M
4. SOCIAL SECURITY NUMBER: 175 14 0460	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 73 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 10.24.21	8. BIRTHPLACE (State or Foreign Country): Georgia
9a. FACILITY NAME (If not institution, give street and number): Liberty Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH: 2606 Liberty Hts Ave.		9c. COUNTY OF DEATH: NA

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: NA	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2902 Lyndhurst Ave		10f. ZIP CODE: 21216	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW11	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th gd. College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Mechanic	16b. KIND OF BUSINESS/INDUSTRY: U.S. Army	
17. FATHER'S NAME (First, Middle, Last): William Trammell		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Holloway	
19a. INFORMANT'S NAME (Type/Print): Maxine Trammell	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2902 lyndhurst Ave		

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place): Garrison Forest	DATE: 7/7	20c. LOCATION — City or Town, State: Catonsville
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Leroy O. Dyett	22. NAME AND ADDRESS OF FACILITY: Leroy o. Dyett & Son Funeral Home 4600 Liberty Heights		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. chronic lung disease (COPD / PACE) Emphysema
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. heart disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [X] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Dr [illegible]	29c. LICENSE NUMBER: D29968	29d. DATE SIGNED (Month, Day, Year): July 3 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 1512 [illegible] Rd Silver Spring Md 20905

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31. DATE FILED (Month, Day, Year): JUL 05 1995 32. [illegible]

DHMH-16 Rev 1/89

95 20483

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WILLIAM H. TOWNES			2. DATE OF DEATH: MONTH JUNE DAY 29 YEAR 95	3. TIME OF DEATH: 1:00 AM
4. SOCIAL SECURITY NUMBER: 215-07-1544	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 79 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): MAY 16, 1916	8. BIRTHPLACE (State or Foreign Country): VIRGINIA
9a. FACILITY NAME (If not institution, give street and number): ST. AGNES HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH: N/A
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: N/A	10c. CITY, TOWN OR LOCATION: BALTIMORE CITY		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2242 W. LEXINGTON STREET		10f. ZIP CODE: 21223		10g. CITIZEN OF WHAT COUNTRY? USA.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10TH GRADE; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LONGSHOREMAN	16b. KIND OF BUSINESS/INDUSTRY: WATER FRONT		
17. FATHER'S NAME (First, Middle, Last): LOUIS TOWNES		18. MOTHER'S NAME (First, Middle, Maiden Surname): ELIZABETH CHEEKS		
19a. INFORMANT'S NAME (Type/Print): EASTER TOWNES	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2242 W. LEXINGTON ST., BALTO, MD. 21223			
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): NEW CATHEDRAL CEMETERY	DATE: 7-6-95	20c. LOCATION — City or Town, State: BALTIMORE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: J. H. Brown	22. NAME AND ADDRESS OF FACILITY: JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. OVERWHELMING FUNGAL SEPSIS	19d.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. NECROTIC PANCREAS	24d
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. ACUTE RENAL FAILURE	24d.
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [X]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Surgical ICU resident	1601	JUNE 29, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARK E. PETRITES MD St. Agnes Hospital 900 Caton Ave Baltimore MD 21229

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUL 06 1995	Lisa Davidson Randall

DHMH-16 Rev 1/89

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95 20484

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Robert R. VOLZ , Sr.			2. DATE OF DEATH (Month, Day, Year): July 2, 1995	3. TIME OF DEATH: 4:00 pM
4. SOCIAL SECURITY NUMBER: 212-40-3934	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 51 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Aug. 30, 1943	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital Center		9b. CITY, TOWN OR LOCATION OF DEATH: Rossville		9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Edgewood	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1820 John Drive		10f. ZIP CODE: 21040	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Supervisor	16b. KIND OF BUSINESS/INDUSTRY: Beverage Services	
17. FATHER'S NAME (First, Middle, Last): Raymond Henry Volz		18. MOTHER'S NAME (First, Middle, Maiden Surname): Doris Ruth Arnold	
19a. INFORMANT'S NAME (Type/Print): Sharon J. Volz	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1820 John Drive , Edgewood, MD. 21040		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Ebenezer Meth. Cem. DATE: 7/5/1995	20c. LOCATION — City or Town, State: Baltimore Co., MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: Bruzdzinski Funeral Home P.A. 1407 Eastern Ave. Balt., MD. ,21221		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Intra-abdominal hemorrhage	hours
DUE TO (OR AS A CONSEQUENCE OF):	Bleeding from an end-to-side jejuno-jejunal anastomosis	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.		hours
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Biliary stricture	days
DUE TO (OR AS A CONSEQUENCE OF):		
d.	Cholelithiasis	months

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [X] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: RD 1922	29d. DATE SIGNED (Month, Day, Year): ▶ July 2, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. S. Rana, M.D. 9000 Franklin Square Drive Baltimore, MD 21237		
31. DATE FILED (Month, Day, Year): JUL 0 6 1995	32. REGISTRAR'S SIGNATURE: [signature]	

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10

95 20485

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
PAUL	KENNETH	WILLIAMSON	Jul 3, 1995	7:25 pm M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
213-05-6334	1 [X] M 2 [ ] F	92 YRS.			10-21-1902	Ohio

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Saint Joseph Medical Center	Towson, Maryland	Baltimore

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Baltimore	Towson	1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
103 Kenilworth Park Drive	21204	U. S. A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] YES 2 [X] NO X	1 [ ] YES 2 [X] NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5 +)		
12		Metallurgist	Armco Steel Corp.

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Gailord B. Williamson	Clara Edna Smith

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Margaret Williamson	Same As #10

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify)	Parkwood Cemetery	7-6-95	Parkville, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Wallace S. Brooks Jr.	Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ISCHEMIC CARDIOMYOPATHY	1 YEAR
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CEREBROVASCULAR ACCIDENT
CHRONIC RENAL FAILURE

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [ ] YES 2 [X] NO	HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined		M	1 [ ] YES 2 [ ] NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Joginder P Mehta MD	D41410	▶ 07-03-95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
JOGINDER P. MEHTA, M.D., ST. JOSEPH MEDICAL CENTER, 7620 YORK RD., TOWSON, MD. 21204

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUL 06 1995	Julia Thurlow Marshall

DHMH-16 Rev 1/89

95 20486

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ethel K. Wheeler			2. DATE OF DEATH (Month, Day, Year): July 3, 1995	3. TIME OF DEATH: 10:45 A
4. SOCIAL SECURITY NUMBER: 215-28-9084	5. SEX: 1 ☐ M 2 ☐ F	6. AGE (In yrs. last birthday): 93 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Feb. 27, 1902	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Baymeadow Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: Glen Burnie,	9c. COUNTY OF DEATH: A.A.Co.Md.	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: none	10c. CITY, TOWN OR LOCATION: Balto.City,Md.	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1619 Clarkson St.		10f. ZIP CODE: 21230	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th.Grade; College (1-4 or 5+): none	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Factory Worker	16b. KIND OF BUSINESS/INDUSTRY: Strauss Baer Co.	
17. FATHER'S NAME (First, Middle, Last): William Gadd		18. MOTHER'S NAME (First, Middle, Maiden Surname): Barbara Shuebring	
19a. INFORMANT'S NAME (Type/Print): Mr. Arthur E. Wheeler	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 989 Chestnut Manor Ct. Balto. Md. 21226		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) _____	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cemetery, 7/6/95 DATE	20c. LOCATION — City or Town, State: Balto.Co.Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Daniel A. Naylor	22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home, 130 E. Fort Av Balto. Md. 21230		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cerebro vascular Accident	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☑	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Attendg	29c. LICENSE NUMBER: D 21726	29d. DATE SIGNED (Month, Day, Year): ▶ 7/5/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SURYA P. MURRA MD 203 E Patapsco Av BALTIMORE MD 21225		
31. DATE FILED (Month, Day, Year): JUL 06 1995		

DHMH-16 Rev 1/89

95-3821-510
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95 20487

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BARRINGTON WOOD
2. DATE OF DEATH (Month, Day, Year): JULY 01, 1995
3. TIME OF DEATH: 0807 A M
4. SOCIAL SECURITY NUMBER: 216-50-1457
5. SEX: 1 ☑ M 2 ☐ F
6. AGE (In yrs. last birthday): 46 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Dec. 15, 1948
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 5501 MINNOKA AVENUE
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH: N/A

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: N/A
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 5501 Minnoka Ave.
10f. ZIP CODE: 21215
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): 4
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Librarian
16b. KIND OF BUSINESS/INDUSTRY: Education
17. FATHER'S NAME (First, Middle, Last): Archie Thomas
18. MOTHER'S NAME (First, Middle, Maiden Surname): Clarice Wood
19a. INFORMANT'S NAME (Type/Print): Brenda Wood
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5501 Minnoka Ave. Balto. Md. 21216
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): King Memorial — DATE: 7/6/95
20c. LOCATION — City or Town, State: Balto. Co. Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph L. Russ
22. NAME AND ADDRESS OF FACILITY: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic Cardiovascular Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☒ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home XX Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Dan Locke MD
29c. LICENSE NUMBER: O.C.M.E
29d. DATE SIGNED (Month, Day, Year): ▶ JULY 1, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DANON LOCKE, MD 111 PENN STREET, BALTIMORE, MARYLAND 21201
31. DATE FILED (Month, Day, Year): JUL 06 1995
32. REGISTRAR'S SIGNATURE: Julia Dwalen-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 20488

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Angela Williams			2. DATE OF DEATH (Month, Day, Year): June 23 1995	3. TIME OF DEATH: 12:05 P M
4. SOCIAL SECURITY NUMBER: 217-90-3316	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 33 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): JUNE 28, 1961	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): JOSEPH RICHIE HOSPICE		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH: N/A

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY: N/A	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 828 N. EUTAW ST.		10f. ZIP CODE: 21201	10g. CITIZEN OF WHAT COUNTRY?: U.S.A

11. MARITAL STATUS: 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:	14. RACE — American Indian, Black, White, etc.: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10TH; College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSE KEEPER	16b. KIND OF BUSINESS/INDUSTRY: PRIVATE
17. FATHER'S NAME (First, Middle, Last): RICHARD HARRIS	18. MOTHER'S NAME (First, Middle, Maiden Surname): MAMIE WILLIAMS	
19a. INFORMANT'S NAME (Type/Print): CYNTHIA MORGAN-MCIVER	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1510 GUILFORD AVE. BALT. MD. 21202	
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): SACRED HEART OF JESUS DATE	20c. LOCATION — City or Town, State: DUNDALK MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]	22. NAME AND ADDRESS OF FACILITY: GARY T. MARCH FUNERAL HOME PA 270 HILTON AVE BALT. MD. 21229	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory erreat, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiopulmonary arrest	6 "
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Mets to head, spine, liver, & the lung	4-5 mos
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Ca of breast	1 yr.
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.: n/a

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE DF DEATH? 1 ☐ YES 2 ☑ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

25. WAS CASE REFERREO TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) HOSPICE	
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end dua to the cause(a) and manner as stated.
2 ☐ MEOICAL EXAMINER: On the basle of axamination and/or investigation, in my opinion, death occured at the time, data and placa, and dua to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Michael R. Hayes, MD	29c. LICENSE NUMBER: D02290	29d. DATE SIGNED (Month, Day, Year) ▶ 6/26/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Richard S. Hayes	527 Linden Ave 21201	
31. DATE FILED (Month, Day, Year): JUL 06 1995 Julia	32. REGISTRAR'S SIGNATURE: Brenda Randall	

DHMH-16 Rev 1/89

2

95 20489

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MATTIE JAN WARFIELD					2. DATE OF DEATH: MONTH JULY DAY 1 YEAR 1995	3. TIME OF DEATH: 12:09 P M
4. SOCIAL SECURITY NUMBER: 213-38-5312	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 78 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): May 21, 1917	8. BIRTHPLACE (State or Foreign Country): North Carolina
9a. FACILITY NAME (If not institution, give street and number): Fallston General Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Fallston		9c. COUNTY OF DEATH: Harford	
RESIDENCE OF DECEDENT						
10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Kingsville			10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO	
10e. STREET AND NUMBER: 12401 Stoney Batter Road		10f. ZIP CODE: 21087			10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): 1		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife			16b. KIND OF BUSINESS/INDUSTRY: Homemaker	
17. FATHER'S NAME (First, Middle, Last): Clarence Hanners					18. MOTHER'S NAME (First, Middle, Maiden Surname): Rosebelle Edwards	
19a. INFORMANT'S NAME (Type/Print): Allen T. Warfield		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12401 Stoney Batter Road Kingsville, Md. 21087				
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or otherplace): Fork Christian Ch. Cem. DATE July 5, 1995			20c. LOCATION — City or Town, State: Kingsville, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: E. F. Lassahn		22. NAME AND ADDRESS OF FACILITY: E. F. Lassahn Funeral Home 11750 Belair Road Kingsville, Maryland				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Acute Cerebrovascular Accident	1 minute
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Atherosclerotic Vascular Disease	15 years
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
M.D. MD	D34652	JULY-5-95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SCOTT HASWELL 2 NORTH AVE. BEL AIR MARYLAND 21014

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUL 0 6 1995	Julia Henderson Randall

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DHMH-16 Rev 1/89

95 20490

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARIA X. WOHLMUTH
2. DATE OF DEATH — MONTH: 7 DAY: 3 YEAR: 95
3. TIME OF DEATH: 9:45 A.M.
4. SOCIAL SECURITY NUMBER: 197-44-0342
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 90 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Feb. 22, 1905
8. BIRTHPLACE (State or Foreign Country): Germany
9a. FACILITY NAME (If not institution, give street and number): Bon Secours Extended Care
9b. CITY, TOWN OR LOCATION OF DEATH: Ellicott City
9c. COUNTY OF DEATH: Howard

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Howard
10c. CITY, TOWN OR LOCATION: Columbia
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 9590 Standon Place
10f. ZIP CODE: 21045
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Own Home
17. FATHER'S NAME (First, Middle, Last): Unknown
18. MOTHER'S NAME (First, Middle, Maiden Surname): Unknown
19a. INFORMANT'S NAME (Type/Print): Joseph H. Wohlmuth (son)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6003 Jacobs Ladder Columbia, Maryland 21045
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) — DATE: Metro Crematory July 7, 1995
20c. LOCATION — City or Town, State: Catonsville, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: R. Clay Witzke
22. NAME AND ADDRESS OF FACILITY: Leroy M & Russell C Witzke Funeral Homes 1630 Edmondson Avenue Catonsville Maryland

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pneumonic	
DUE TO (OR AS A CONSEQUENCE OF):	b. Stroke	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Gary C. Prado MD
29c. LICENSE NUMBER: D22567
29d. DATE SIGNED (Month, Day, Year): 7/5/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 11055 Little Patuxent Parkway, Columbia, Maryland
31. DATE FILED (Month, Day, Year): JUL 06 1995
32. REGISTRAR'S SIGNATURE: Julia Gardner Randall

DHMH-16 Rev 1/89

12

95 20491

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Edward Chauncey Wylie
2. DATE OF DEATH: MONTH June DAY 15 YEAR 95
3. TIME OF DEATH: 1600 pM
4. SOCIAL SECURITY NUMBER:
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday) YRS.: IF UNDER 1 YEAR — MONTHS 0 DAYS 0; IF UNDER 24 HRS. — HOURS 0 MIN. 45
7. DATE OF BIRTH (Month, Day, Year): June 15, 95
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): University of Maryland MEdical System
9b. CITY, TOWN OR LOCATION OF DEATH: BAltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE:
10b. COUNTY:
10c. CITY, TOWN OR LOCATION:
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER:
10f. ZIP CODE:
10g. CITIZEN OF WHAT COUNTRY?
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last)
18. MOTHER'S NAME (First, Middle, Maiden Surname)
19a. INFORMANT'S NAME (Type/Print)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE:
20c. LOCATION — City or Town, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald Wade, Dir.
22. NAME AND ADDRESS OF FACILITY: State Anatomy Board, 655 W. Baltimore St., Balto., MD 21201

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Extreme Prematurity — 45 MINS

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Gena E. Taylor MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ June 15,95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): GENA E TAYLOR, MD UMMS 22 S.Green ST Baltimore, MD.21201

31. DATE FILED (Month, Day, Year): JUN 30 1995
32. REGISTRAR'S SIGNATURE: Randall

DHMH-18 Rev 1/89

95 20492

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Gertrude SEAVER WARD		2. DATE OF DEATH (Month, Day, Year): June 30, 1995	3. TIME OF DEATH: 7:54 a M
4. SOCIAL SECURITY NUMBER: 199 22 7187	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 65 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): SEPT. 22, 1929
8. BIRTHPLACE (State or Foreign Country): PENNSYLVANIA			
9a. FACILITY NAME (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH: ROSEDALE	9c. COUNTY OF DEATH: Baltimore County	

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: N/A	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 5213 McFAUL ROAD	10f. ZIP CODE: 21206	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: KOREA	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12YRS. College (1-4 or 5 +): 2YRS.	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): REGISTERED NURSE	16b. KIND OF BUSINESS/INDUSTRY: FORT HOWARD HOSPITAL	
17. FATHER'S NAME (First, Middle, Last): WILLIAM JOSEPH SEAVER	18. MOTHER'S NAME (First, Middle, Maiden Surname): BERTHA FESSER		
19a. INFORMANT'S NAME (Type/Print): DOUGLAS E. WARD	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5213 McFAUL ROAD BALTIMORE, MARYLAND 21206		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): DULANEY VALLEY MEMORIAL DATE 7-3-95	20c. LOCATION — City or Town, State: TIMONIUM, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD - PARKVILLE		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF):	3 hours
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	D21256	▶ June 30, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Theodore Harrison, M.D. 9000 Franklin Square Drive, Baltimore, MD 21237

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUL 06 1995	[signature]

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DHMH-16 Rev 1/89

95 20493

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Evelyn L. Young		2. DATE OF DEATH: Month July, Day 4, Year 1995	3. TIME OF DEATH: 5:50 AM
4. SOCIAL SECURITY NUMBER: 216-01-7572	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 83 YRS. (If under 1 year: Months; If under 24 hrs.: Days, Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): July, 30, 1911
8. BIRTHPLACE (State or Foreign Country): Pennsylvania			
9a. FACILITY NAME (If not institution, give street and number): St. Agnes Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH: Balto. City, Md,	9c. COUNTY OF DEATH: none

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: none	10c. CITY, TOWN OR LOCATION: Balto. City, Md.	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2708 Ottawa Ave.		10f. ZIP CODE: 21230	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th. Grade; College (1-4 or 5+): none	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Harry Irvin Miller		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Elizabeth Delancy	
19a. INFORMANT'S NAME (Type/Print): Mr. Martin G. Young, 3rd.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2708 Ottawa Ave, Balto. Md. 21230	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Mem. Park,	DATE: 7/7/95	20c. LOCATION — City or Town, State: Elkridge, Howard Co. Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Daniel A. Taylor		22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home, 130 E. Fort Ave. Balto. Md. 21230	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	urinary tract infection	1 wk
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Atherosclerotic cardiovascular disease	yrs
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D44071	29d. DATE SIGNED (Month, Day, Year): 7/4/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PAIRACH PINTAVORN, MD — THE JOHNS HOPKINS HOSPITAL ROSS 958 720 RUTLAND AVE BALTIMORE, MD 21205		
31. DATE FILED (Month, Day, Year): JUL 06 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall	

DHMH-18 Rev 1/89

95 20494

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Alma C. Alban
2. DATE OF DEATH — MONTH: 07 DAY: 03 YEAR: 95
3. TIME OF DEATH: 12 15 PM
4. SOCIAL SECURITY NUMBER: 220-05-5579
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 83 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): July 12, 1911
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Medbridge Nursing Home
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: N/A
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1734 Lancaster Street
10f. ZIP CODE: 21231
10g. CITIZEN OF WHAT COUNTRY?: U. S. A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4 or 5+): 2 Years
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Employment Interviewer
16b. KIND OF BUSINESS/INDUSTRY: State of Maryland
17. FATHER'S NAME (First, Middle, Last): John L. Cermak
18. MOTHER'S NAME (First, Middle, Maiden Surname): Emily Kostel
19a. INFORMANT'S NAME (Type/Print): George H. Alban III (Son)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1734 Lancaster Street, Baltimore, Md. 21231
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Bohemian National Cem. — DATE: 7/7/95
20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Matthew Cupit
22. NAME AND ADDRESS OF FACILITY: Schimunek Funeral Home, 3331 Brehms Lane, Baltimore, Md. 21213

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Dementia — 6 YEARS

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Atherosclerotic Heart Disease — 6 YEARS

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Achondroplasia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: John D.O.
29c. LICENSE NUMBER: M 35593
29d. DATE SIGNED (Month, Day, Year): 7/4/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOHN J. LOH, D.O. 1124 MACE AVE, BALTO. MD 21221
31. DATE FILED (Month, Day, Year): JUL 0 7 1995
32. REGISTRAR'S SIGNATURE: Julia Marchesani Randall

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DHMH-16 Rev 1/89

95 20495

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Thelma Annette BROOKS		2. DATE OF DEATH (Month, Day, Year): July 01, 1995	3. TIME OF DEATH: 11:42 P.M
4. SOCIAL SECURITY NUMBER: 213-03-9483	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 80 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): July 6, 1914 — 8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore	9c. COUNTY OF DEATH: Baltimore County	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: N/A	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 4611 Chatford Avenue	10f. ZIP CODE: 21206	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4 or 5+): N/A	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Retail Sales	16b. KIND OF BUSINESS/INDUSTRY: Department Store	
17. FATHER'S NAME (First, Middle, Last): Adolph T. Grauer	18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Agnes Loftus		
19a. INFORMANT'S NAME (Type/Print): Joseph Lester Brooks (Husband)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4611 Chatford Avenue, Baltimore, Md. 21206		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cemetery — DATE: 7/5/95	20c. LOCATION — City or Town, State: Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert Podlach	22. NAME AND ADDRESS OF FACILITY: Schimunek Funeral Home 3331 Brehms Lane, Baltimore, Md. 21213		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Breast Cancer	1 year
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Rafael Perez-Mera	29c. LICENSE NUMBER: D10613	29d. DATE SIGNED (Month, Day, Year): ▶ July 02, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Rafael Perez-Mera, MD 404 Eastern Blvd. Baltimore, Md 21221		
31. DATE FILED (Month, Day, Year): JUL 07 1995	32. REGISTRAR'S SIGNATURE: Julia Thurlow Randall	

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95 20496

FilmG, 725, item #1, 7/7/95, cyw

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ~~MARY L. CARTER~~ MARY L. BROWN-CARTER		2. DATE OF DEATH: MONTH 07 DAY 05 YEAR 1995	3. TIME OF DEATH: 1.05 A M
4. SOCIAL SECURITY NUMBER: 217-22-2614	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 85 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 06-10-10
8. BIRTHPLACE (State or Foreign Country): GEORGIA			
9a. FACILITY NAME (If not institution, give street and number): MERCY HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE	9c. COUNTY OF DEATH: BALTIMORE	

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: n/a	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 611 S. CHARLES STREET		10f. ZIP CODE: 21230	10g. CITIZEN OF WHAT COUNTRY?: U.S.A

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10 th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE	16b. KIND OF BUSINESS/INDUSTRY: DOMESTIC	
17. FATHER'S NAME (First, Middle, Last): NED ARVINGER	18. MOTHER'S NAME (First, Middle, Maiden Surname): ADDIE GRANT ARVINGER		
19a. INFORMANT'S NAME (Type/Print): FREDDIE BROWN	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2616 BERYL AVENUE, BALTIMORE, MD 21205		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): ARBUTUS MEMORIAL PARK; DATE: 7-8	20c. LOCATION — City or Town, State: ARBUTUS, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]	22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH FH.-1101 E. NORTH VA		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	RESPIRATORY FAILURE	WEEKS
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	END STAGE DEMENTIA	YEARS
DUE TO (OR AS A CONSEQUENCE OF):		
c.	ANEMIA	YEARS
DUE TO (OR AS A CONSEQUENCE OF):		
d.	CHRONIC HYPONATREMIA	MONTHS

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PERIPHERAL VASCULAR DISEASE
NON-INSULIN DEPENDENT DIABETES

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☑

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO; 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: P08550	29d. DATE SIGNED (Month, Day, Year): ▶ 7/5/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): NICOLA CASCELLA MERCY HOSPITAL 301 ST PAUL PLACE BALTIMORE MD 21202		
31. DATE FILED (Month, Day, Year): JUL 07 1995	32. REGISTRAR'S SIGNATURE: Julia [signature]	

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DHMH-18 Rev 1/89

95 20497

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Wan Tao Cheung			2. DATE OF DEATH (Month, Day, Year): July 3, 1995	3. TIME OF DEATH: 7:25 P. M
4. SOCIAL SECURITY NUMBER: 220-54-6964	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 77 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Aug. 21, 1917	8. BIRTHPLACE (State or Foreign Country): China
9a. FACILITY NAME (If not institution, give street and number): 12 Crafton Road		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 12 Crafton Road		10f. ZIP CODE: 21221	10g. CITIZEN OF WHAT COUNTRY?: China

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Chinese

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Unknown; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): See Son Cheung		18. MOTHER'S NAME (First, Middle, Maiden Surname): Lai Lee	
19a. INFORMANT'S NAME (Type/Print): Mr. Gordon Lew (son)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12 Crafton Road, Baltimore, MD 21221	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Lorraine Park Cemetery	DATE: 7/8	20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]		22. NAME AND ADDRESS OF FACILITY: Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications thet ceused the death. Do not enter the mode of dying, such es cerdiec or reepiratory srrest, shock, or heart feilure. Liet only one ceuse on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Finel disease or condition resulting in death) →
a. Lung carcinoma, nonsmall cell — 3 months
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if sny, leeding to immediete ceuse. Enter UNDERLYING CAUSE (Disease or injury thet initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	26a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY M	26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	26d. DESCRIBE HOW INJURY OCCURED		
	26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D.	29c. LICENSE NUMBER: D14959	29d. DATE SIGNED (Month, Day, Year): ▶ 7/6/95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): FELIX TAN, M.D. 4000 ERDMAN AVE, BALTIMORE, MD 21213

31. DATE FILED (Month, Day, Year): JUL 07 1995	32. REGISTRAR'S SIGNATURE: [signature] Julia Strother Randall

OHMH-16 Rev 1/89

95 20498

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): THOMAS EDWARD CRILLEY			2. DATE OF DEATH (Month, Day, Year): July 1, 1995	3. TIME OF DEATH: 7:45 P. M
4. SOCIAL SECURITY NUMBER: 208 16 2284	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 70 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 08 17 24	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): 439 Hornel Street		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH: N/A
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY: n/a	10c. CITY, TOWN OR LOCATION: Baltimore		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 439 Hornel Street		10f. ZIP CODE: 21224		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: W.W. 2	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk		16b. KIND OF BUSINESS/INDUSTRY: Steel	
17. FATHER'S NAME (First, Middle, Last): Arthur Crilley		18. MOTHER'S NAME (First, Middle, Maiden Surname): Magdalena Myers		
19a. INFORMANT'S NAME (Type/Print): Josephine H. Crilley		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 439 Hornel Street Balto.,Md. 21224		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Oak Lawn Cemetery DATE: 7-5-95		20c. LOCATION — City or Town, State: Eastwood,Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Charles D. Zeiler		22. NAME AND ADDRESS OF FACILITY: Charles S. Zeiler & Son Inc. 6224 Eastern Ave. Balto.,Md.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CORONARY Artery Disease	15 yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PARKINSON'S Disease

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [X] NO [ ] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO; 28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: J.M. Richardson MD	29c. LICENSE NUMBER: D36430	29d. DATE SIGNED (Month, Day, Year) ▶ 7/7/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J.M. RICHARDSON MD 2112 Dundalk Ave Baltimore MD 21222		
31. DATE FILED (Month, Day, Year): JUL 07 1995	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Charlotte L Collins			2. DATE OF DEATH (Month, Day, Year): July 03 1995	3. TIME OF DEATH: 2203 M
4. SOCIAL SECURITY NUMBER: 215-22-8615	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 79 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Dec 13, 1915	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Union Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH: Baltimore City

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore City	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2953 Miles Avenue		10f. ZIP CODE: 21218	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cab Driver	16b. KIND OF BUSINESS/INDUSTRY: Public Transportation	
17. FATHER'S NAME (First, Middle, Last): Leo Crawford		18. MOTHER'S NAME (First, Middle, Maiden Surname): Unknown	
19a. INFORMANT'S NAME (Type/Print): Ella Preston	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2626 N. Calvert Street Baltimore, MD 21218		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory	DATE: 7/5	20c. LOCATION — City or Town, State: Catonsville, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Tracy Hess Carpenter	22. NAME AND ADDRESS OF FACILITY: Burgee-Henss Funeral Home 3631 Falls Road Baltimore, MD 21211		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Atherosclerotic Cardiovascular Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: J. Caron Locke MD	29c. LICENSE NUMBER: O.C.M.E.	29d. DATE SIGNED (Month, Day, Year): July 04 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. CARON LOCKE MD	111 Penn Street, Baltimore, Maryland 21201	
31. DATE FILED (Month, Day, Year): JUL 07 1995	32. REGISTRAR'S SIGNATURE: [signature]	

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DHMH-16 Rev 1/89

95 20500

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
FRANCIS	J.	COLLETTA	07/04/95	1451 PM

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
218-40-9646	1 [X] M 2 [ ] F	52 YRS.			September 28, 1942	New Jersey

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Atlantic General Hospital	Berlin, Md.	Worcester

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Anne Arundel	Glen Burnie	1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
251 Hammarlee Road	21060	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES 1962 - 1964	1 [ ] YES 2 [X] NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
	6	Adjudicator	Social Security

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Camillo E. Colletta	Helene Zelznok

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Lorraine W. Colletta	Same as10e

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) ____	Crownsville Vet. Cemetery	7/10/95	Crownsville, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Ronald C. Schleigh Jr.	Leonard J. Ruck Funeral Home, Inc. 5305 Harford Rd. Balto. Md. 21214

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ACUTE MYOCARDIAL INFARCTION	FEW MINUTES
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [X] YES 2 [ ] NO	HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] YES 2 [ ] NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Dorothy C. Holzworth, M.D.	D 06241	▶ 7-4-95

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DOROTHY C. HOLZWORTH 203 SNOW ST. SNOW HILL, MD. 21863

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUL 07 1995	Marlene Kendall

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